INVEST EARLY IN MAINE

AWorking Plan for Humane Early Childhood Systems

2007 Edition

For Dylan Peavey (1997-1999) and every young child in Maine

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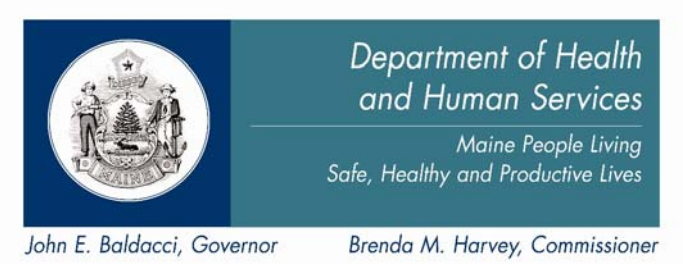
For More Information, contact:
Sheryl Peavey
Director, Early Childhood Initiative
Staff, Task Force on Early Childhood
207.287.3339
sheryl.peavey@maine.gov



INVEST EARLY IN MAINE

A WORKING PLAN FOR HUMANE EARLY CHILDHOOD SYSTEMS

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FORWARD

Since 1998, the Governor's Children's Cabinet has supported a statewide coordinating collaborative to convene stakeholders and agencies/programs to improve systems for young children and their families. In 2003, the federal Maternal and Child Health Bureau provided the financial support to formally promote effective systems change through Maine's *Early Childhood Initiative.* The Initiative has served as the tool to focus years of research, dialogues and advocacy from the Children's Cabinet's Task Force on Early Childhood and its partners into a thoughtful, intentional blueprint for how Maine can demonstrate the esteem in which we hold our children.

Using the *Working Plan for Humane Early Childhood Systems for Maine,* the Early Childhood Initiative seeks to integrate state and community activity related to early childhood systems. The state plan presents some of the best thinking of scores of experts in Maine, including parents and other family members, neighbors, government agencies, community non-profit organizations, business leaders, economists, and service providers. These dedicated groups have analyzed the current resources, costs, gaps, and strengths of our public health and social service systems.

As we do our work together, we remain mindful to support our vision of **humane** systems, policies, programs, and services for the people of Maine:

1. Honor and respect the dignity of all people involved, and of their cultures.
2. Consider that everyone is an "expert" and honor all voices, especially those who have historically not been included in the design of the policies that affect them.
3. Family and community involvement from start to finish is essential.
4. We use simple and clear, non-jargon, non-bureaucratic, non-violent language and communication. This means not using acronyms unless we are willing to explain what the letters mean, and not using terms such as "targeted" and "surveillance" unless we define them first.
5. Draw on the strengths, resiliency, and resources of all people involved, including the families and communities that we serve.
6. Collect, track, analyze, and use data in an honest, clear, and accurate way that is true to the basic principles of public health and that serves as the foundation for action.
7. Advocate for ways to humanize and dignify systems, policies, programs, and services in the long term.
8. Be faithful to the purpose of public health, which is to foster the conditions that will enable the whole population to achieve optimal health. To serve the health of the public, we have to take care of our own health.
9. Be non-judgmental, and realize that behind every statistic, every risk factor, every death is a real human being, with all the complexity, magnificence, and potential for good that is in each of us.
10. Be relationship-centered...i.e. carry out the work of public health within a context that appreciates the vital role of loving and thoughtful human relationships in promoting health and safety and justice.

Our 2007 Edition is structured around a new format we hope will be more reader-friendly. Each recommendation describes (a) Where We Are Now, (b) Where We Want to Be, (c) How to Get There, (d) Who Leads, and (e) When the major activities will be accomplished for each goal.

Together, we can make a difference for children and families in Maine.

INTRODUCTION TO EARLY CHILDHOOD SYSTEMS IN MAINE

Maine's early childhood family support, health, education and community systems remain-fragmented, silo-funded, and a drain on our social and state capital. Inadequate investments in early childhood prevention, intervention and resources continue to yield high long-term costs. As a consequence, these issues negatively affect children's school readiness, the ability of families to work productively, an, ultimately, Maine's economic prosperity. The support of the Maternal and Child Health Bureau State Early Childhood Comprehensive Systems (SECCS) grant is making it possible for Maine to change that landscape through the focus and commitment of our Early Childhood Initiative (ECI).

Maine communities have long recognized the need to change the way state and local agencies work with young children and their families. As a result, we have taken action. We established a Governor's Children's Cabinet in 1995, consisting of the Commissioners of Health and Human Services, Education, Juvenile Services, Labor, Public Safety as well as the Attorney General and State Planning Office. We set up regional Children's Cabinets to mirror this structure. We created an Early Care and Education Task Force as a Children's Cabinet Initiative. We organized START ME RIGHT, the Alliance for Children's Care, Education, and Supporting Services (ACCESS), the Home Visiting Coalition, and Child Abuse and Neglect Councils to work on children's issues by bringing professionals, providers, and parents to the proverbial policy "table." Together these child advocacy groups coalesced and successfully enacted sound legislation that directed our tobacco settlement monies to prevention and health initiatives; increased the child care tax credit for families with children in quality child care; and strengthened the newborn screening program to look for 27 different genetic conditions.

But these successes--and the hard work that went into them—have continued to fragment the early childhood system even though we've formed new alliances and bridged individual silos. For example, supporting children's mental health was not always the objective of primary health care or even child care providers. Keeping families intact was previously the exclusive work of child protective caseworkers, not Pre K teachers or librarians. Making sure our children were immunized was not always a measure of community support for families. Separately, groups have had success within their discrete fields, but systemically, we have not claimed ownership of the entire system. Indeed, we are still defining what constitutes an early child system. So, despite our efforts, substantial numbers of Maine's young children continue to enter their school years lacking physical and emotional health and safety; a sense of their own worth and dignity; a resilient spirit; and the capacity to thrive in their schools, families, and communities.

In 2003, with the dedicated resources of the SECCS grant to coordinate our work, members of the Early Care and Education Task Force began the dialogue of addressing change holistically and systemically. The Task Force broadened its scope of work, renamed itself the Task Force on Early Childhood and began to function as a statewide coordinating collaborative that included parents, policymakers, and professionals dedicated to young children. The Task Force purview now includes (a) child physical, social, emotional and mental health, (b) early care and education, (c) parent education, and (d) family support. Organized as a group of action teams, the Task Force developed a comprehensive list of issues faced by Maine children and families and documented our state's human and material strengths and assets. From this, the Task

Force generated priority recommendations and began the daunting task to coordinate polices and service delivery systems that support children, families, and communities in Maine.

Using a child-centric model to develop a state systems change plan, we grouped our recommendations as strategic themes (Family, Health, Early Care and Education, Community, and State). By organizing in this way, the child remains at the center of our work. Each strategic theme represents the points at which the child touches each part of the early childhood system in his or her daily life beginning with the most important part, the family. This approach has helped us understand a highly complex and interwoven system that cannot simply be disassembled and rearranged like "Lincoln Logs."

Supporting our strategic themes and the recommendations is data: qualitative, quantitative data from the disparate collection methods we currently use. As outlined below, these data show the need for changes in each part of the system, and once they occur, a comprehensive change in the entire system will happen because we are doing our work with mindfulness to realistic, long term, actionable strategies.

Family

Parenting education and family supports are threatened by the general lack of awareness of an economic reality--the generous return on investing in parenting education and the recruitment and exchange of social capital.[1] Unfortunately, most funding streams (including Medicaid and CAPTA funds) are designed to consider a single client with medically-necessary needs and do not consider the environmental context for the needs of a child or his caregivers. Historically, most authorizations for treatment or case management services provide no incentive to embrace the family and their needs among such services as behavioral health, Head Start, home visiting, CDS, child welfare, or family independence. We are making inroads with those policies,[2] but a shift in practice is not quick to follow.

[1] Lin, Nan. *Social Capital: A theory of social structure and action*. Cambridge University Press, 2001.

[2] For instance, we have repealed some sections of MaineCare regulations related to home based mental health care services and instituted regulations that do not require families to receive Case Management Services in order to receive Child and Family Behavioral Health Treatment Services. FMI: www.gearparentnetwork.com.

Health

Health care coverage, especially for preventive health services, creates an environment for improved health outcomes.[3] Insurance coverage of well-child care in Maine has improved our rates of immunization and early detection of health problems and developmental delays. But 7% of children under 18 in Maine still are uninsured.[4] Four out of every 10 uninsured children in Maine live in a family earning less than $20,000 per year.[5] Our data[6] show that Maine children without health insurance are less likely to have a regular health care provider; less likely to have had a dental visit in the last year; and more likely to be in fair or poor health than low income, insured children.

However, access to health coverage and medical homes in Maine is inconsistent. Fourteen of the state's 16 counties contain at least one town that is a federally designated primary care health professional shortage area; 15 counties contain towns that have federally designated medically underserved areas or populations[7]. As noted locally, "It strains our image as a just and humane society when significant portions of the population endure avoidable pain, suffering and illness because of an inability to pay for health care."[8]

Early oral health intervention also remains elusive for many children. Dental caries experience was found among roughly a third or more of Maine's young children.[9] In fact, in Washington County, 48% of one to four year olds were diagnosed with dental decay.[10] In 2002, there were only ten dentists in Maine who

[3] Chang DI, Bultman L, Drayton VL, Knight EK, Rattay KT, Barrett M. *Beyond medical care: how health systems can address children's needs through health promotion strategies*. Health Aff (Millwood) 2007; 26:466-73.

[4] *2007 Maine Kids Count*. Maine Children's Alliance, Augusta, ME: 2007.

[5] Cook, Allison; Miller, Dawn; and Zuckerman, Stephen. *Health Insurance Coverage in Maine*, 2004–2005. Commissioned by the Maine Health Access Foundation. Augusta, ME: May 2007.

[6] *Health Insurance Coverage among Maine Residents: The Results of a Household Survey 2002*. Institute for Health Policy, Muskie School of Public Service, Univ. of Southern Maine. May 2003.

[7] Maine Office of Rural Health and Primary Care, Apr. 2007: http://www.maine.gov/dhhs/boh/orhpc/documents/MUA_MUP_07.pdf, accessed July 5, 2007

[8] Maine Children's Alliance, 1996. Issue Brief: *Child Health Care Access Project: Who are the Uninsured in Maine?* See: http://www.mainechildrensalliance.org/am/publish/article_67.shtml

[9] Camick S, Alley T. Oral Health of Washington County Preschool Children. June 1999

[10] Camick S, Alley T. Oral Health of Washington County Preschool Children. June 1999.

specialized in pediatric dentistry. [11] Most of Maine is federally designated as dental health professional shortage areas; there are federally designated dental health professional shortage areas in every county in the state.[12] The 1999 Smile Survey found that the three most common reasons why young children in Maine did not get dental care when they needed it were the inability to pay for it, lack of insurance, and dentists not accepting Medicaid/insurance.[13]

Early Care and Education

Quality, affordable early care and education is integral to the lifetime success of Maine's children, prepares the future workforce and enables parents to support their families. Yet available child care programs, adequate child care subsidies for low income children, and limited quality create serious obstacles for Maine's families and their children. This is further convoluted by the low wages of child care workers and the seemingly high cost of care. Infants and toddlers, children with special needs, and low-income working families face even more complex challenges to high quality care.

In Maine, we estimate that 65% (approx. 46,000) of our preschoolers have working parents.[14] Data suggest that as many as 81% of Maine's poor infants and toddlers need child care at some point so their parents can work—as many as 4,900 children under age 2.[15] Yet, there are only 27,600 spaces in licensed child care programs for all children under five,[16] and there are about 5,000 young Maine children who are waiting for licensed child care.[17] And for children with special learning and/or health related needs, being ready to enter and succeed in school partly depends on having had early intervention and ongoing supports in place. Our 2006 market rate study estimates that 6% of all children attending child care in Maine have special needs.[18] However, despite the investment of federal and state dollars, Maine's subsidies reach only about 38% of the children who are eligible.[19]

Head Start and Early Head Start mitigate this issue of accessibility to a small degree. Maine serves nearly 4,000 children annually in twelve regional programs and three Tribal Head Starts. The Maine Children's Alliance estimated that in 2006 there were 12,266 children eligible for Head Start in Maine but 67.7% were not being served.[20]

The quality and cost of early care and education are factors that often leave parents facing difficult and compromising choices about their children's well-being. It is not known exactly how many Maine children receive high quality child care, since little is known about the informal care provided by family, friends and/or neighbors. We do know that as of July 2007, not even 2% of all programs were nationally accredited.[21] Still, Maine parents may have to pay as much as $10,400 for an infant in full time center based care.

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[11] Bureau of Health, Maine Department of Human Services. Maine Cooperative Health Manpower Resource System: General Practice and Specialist Dentists, 2002. http://www.maine.gov/dhs/bohodr/index.htm

[12] Maine Office of Rural Health and Primary Care, April 2007. Available at: www.maine.gov/dhhs/boh/orhpc/documents/HPSA_DCAA_07.pdf, accessed July 5, 2007.

[13] Oral Health Program, Bureau of Health, Maine Department of Health & Human Services. Oral health access/infrastructure (fact sheet), 2004.

[14] US Census states that 65% of children under the age of SIX have all parents in the labor force. We use the 65 percentile to extrapolate the number of Maine's children under 5 years old with all parents working.

[15] National Center for Children in Poverty (www.NCCP.org), national data extrapolation using poverty rates

[16] ME Dept of Health and Human Services

[17] *Maine Child Care Workforce Climate Report and Market Rate Analysis, July 2006.* Prepared by: Digital Research, Inc. Kennebunk, ME and Diane Schilder, PhD., Evaluation Analysis Solutions, Inc. Cambridge, MA.

[18] *Maine Child Care Workforce Climate Report and Market Rate Analysis, July 2006*

[19] ME Department of Health and Human Services data 2006.

[20] Maine Children's Alliance. *Maine's Kids Count 2006.*

[21] *Maine Roads to Quality Traffic Report- 6/23/07. http//www.muskie.usm.maine.edu/maineroads*

Yet, child care labor costs can take as much as two-thirds of the child care budget (65%).[22] Our Department of Labor reports that 595 occupations out of 697 occupations registered in Maine are paid more than child care workers.[23] Statewide, we struggle to change the public mindset of the value of investing in our children and those who care for them.

Local and Statewide Community

Maine's population is aging. The State Planning Office projects that in 2015, 18.1% of the state population will be under 18 years and there will be more people 65 years and older in the state than children under 18.[24] The tax burden[25] has brought misdirected and inordinate attention for reduction in state spending, particularly education[26] and human services.

During the past four years, Maine has focused its approach to address the problem that thousands of our children from birth to five years old are at risk of school failure and poor health outcomes in our state. The work of the Task Force and its members often encounter other pressing needs facing Maine's legislature and voters--from road improvements in this rural state and energy assistance during harsh northeast weather, to schools, health care, and even crowded prisons. Legislative term limits, restricted resources and silo-driven hurdles continue to limit our success for young children.

The Intervention

Maine has been a national leader in demonstrating its vision of connecting communities to better serve young children. We strive to foster conditions for Maine children and families to achieve optimal health, knowing that health encompasses the social, economic and environmental contexts that shape their lives. Critical to this process is investing in a sustained focus on systems change. The funding, but equally the attention, from the federal Maternal and Child Health Bureau has given us the validity, credibility, authority and resources to effect visible systems change. Using resources established nationally through the SECCS effort, including networking meetings, technical assistance, listservs, and alerts to new research and promising practices, Maine has focused its vital systems change work. We are moving forward to address some of the underlying social and cultural norms that influence the ways in which we value young children and their families.

We have used our SECCS funds to organize and propel our work through the Task Force on Early Childhood. During our planning phase, we hosted Maine's Early Childhood Future Search using an intense, evidence based methodology to discover common ground and initiate highly collaborative action to make systems change happen.[27] We are translating the research showing that the first three years of life are the most important for healthy child development, and in turn, provide all early care providers, especially parents, with the information and tools to enhance their skills as parents and providers.

We are recognizing that the responsibility to improve the experiences and environments of children lies with both government and the people. Where those roles intersect will define the success and sustainability of the early childhood systems change movement. Maine government can provide the policy framework for the system, such as helping prevent adolescent pregnancies, providing new parents with child development information, offering the resources to mitigate the sense of isolation in our largely rural state, and supporting quality early care and education programs and valuing its workforce.[28] Public will should also reflect a culture that strongly supports the need for these kinds of policies. It must marry the value Mainers place on individual independence with the value of community and the strong economic growth that happens when communities and society as a whole invest early in our youngest children.

The Benefit

From our vantage point in the uppermost corner of the country, we can see that people are paying attention to early childhood nationally. But in light of our guiding principles adopted from Future Search we will consider the global context for change, but hold ourselves

[22] *2004 Cost/Quality Study in Preschool Classrooms*

[23] *Occupational Employment Statistics.* Maine Department of Labor. November, 2006.

[24] Maine State Planning Office. Maine State Population Forecast by Age (single years) to 2017. December 2003. Available from: URL: http://www.state.me.us/spo/economics/economics/pdf/ageprojections12_03b.pdf

[25] *LD 1 PROGRESS REPORT 2006.* Maine State Planning Office, Augusta, ME. January 2007.

[26] Issue Brief No. 16, *A Plan to Reform and Reduce Maine's Taxes*. Maine Heritage Policy Center, June 2007.

[27] Janoff, S. and Weisbord, M. *Future Search: An Action Guide to Finding Common Ground in Organizations and Communities, 2nd Ed.* Berrett Koehler Publishers, CA: 2000. For more information about this global approach to systems change, see www.futuresearch.net.

[28] See also: Johnson, K. & Knitzer, J. (2006) *Early Childhood Comprehensive Systems that Spend Smarter.* New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health www.nccp.org.

responsible for local action. We will hold ourselves accountable to make sure the whole system is in the room as we do our work. We will use our historically independent New England mindset to self-manage, as groups, and share the workload. Above all, we will make sure we are keeping our future in mind.

During the past three years of the SECCS project, we have developed and have been implementing the recommendations of *Invest Early in Maine: A Working Plan for Humane Early Childhood Systems*. We have created an Early Childhood Division as the entire Department of Health and Human Services (DHHS) was restructured. We have leveraged funds to support child abuse and neglect prevention through the Center for the Study of Social Policy's Strengthening Families Initiative.[29] We have a statewide campaign, Invest in ME Now,[30] composed of Maine's organizations and associations representing advocates and providers, including: Resource Development Centers, Child Care Directors, Family Child Care Providers, School Age Care providers, Head Start, Child Development Services, MAEYC, and other children's services. We are developing a training infrastructure based on the principles of the Brazelton Touchpoints Center,[31] actively planning a Governor's Community Summit on Early Childhood with support from the National Governor's Association,[32] and are part of a national movement to integrate developmental screening in primary care settings through the ABCD (Assuring Better Child Health and Development) Screening Academy.[33]

The scope of the SECCS intervention can be felt locally. Maine's largest newspaper syndicate just completed a three-part series on child care. Our Infant Toddler Initiative (funded by Zero to Three) completed a Public Service Announcement that has been used for our annual Infant Toddler Awareness Day at the Capitol—because of its content and quality, this PSA was distributed nationally by Zero to Three. The Maine Children's Alliance, a key partner for this effort, has worked extensively with Maine media, particularly with the annual release of the Maine Kids Count data book and the 2007 Children's Mental Health Indicators report. The 123rd Maine Legislature**,** a group with many newly elected officials**,** recently approved a *Resolve for the Commission to Develop a Strategic Investment Plan for Maine's Young Children.* Once established, its work will parallel the Governor's Summit and together will garner widespread public support for early childhood policy changes throughout Maine.

The Maine ECCS project is a thoughtful, intentional way for Maine leadership to demonstrate the esteem in which we hold our children. It underscores a collective understanding that early investment in young children and families yields significant returns in both financial and social capital. A public private partnership of this magnitude reflects highly the commitment of the Governor, state government, and Maine communities. We are driven to strengthen quality, inclusive early care and education and children's services so that they optimize children's curiosity and readiness for school, to support the ability of families to work productively, and to increase the capacity of the state to achieve its economic development goals.

[29] For more information, see: http://www.cssp.org/doris_duke/index.html
[30] For More information, see: http://www.investinmenow.com/
[31] For more information, see: www.touchpoints.org
[32] See: National Governor's Association
[33] For more information, see http://www.abcdresources.org/

1. FAMILY DOMAIN

The Family domain focuses on the important role of parents as nurturers, teachers, protectors, and caregivers of their young children and ways in which other parents as well as formal support systems can assist them in their valuable role. Two critical approaches addressed in the ECI are (1) the support, connections to resources, parent education, and skill development provided through Maine's home visiting program for families of infants and toddlers and (2) parent-organized and parent-led family networks. Home Visitation programs throughout Maine offer voluntary parent education and family supports for first time families with children, prenatal through five years of age. A trained professional visits the families at home and offers a wide range of services depending on the needs, strengths and interests of the parents. Maine Family Networks form around the catchment area of local elementary schools and by age cohort of the children (infants, one-year olds, etc.) to provide early connection to their children's medical, educational, and community homes. Both approaches celebrate and acknowledge the parent and family as the most important "touch point" in the life of their child.

1.1

Maine Family Networks (MFN) will be established by parents of infants and toddlers in every Maine town or city neighborhood.

Where We Are Now

- A formal and uniquely strong connection has been established between MFN and the Task Force on Early Childhood; American Academy of Pediatrics, ME Chapter; and Downeast Health Services. Members of the Task Force are directly involved in designing and developing the concept of family networks. Information about MFN was shared at the AAP Early Childhood Forum on November 4, 2006, drawing more than 250 people from diverse backgrounds and health and social service professions.
- Throughout the year, referrals were received from individual parents. Three town networks were created as result of referrals from a Home Visiting agency: Parents are Teachers Too (PATT) Program of Downeast Health Services. Networks exist in Cumberland/Yarmouth, Ellsworth, Falmouth, Freeport, Hancock, Lamoine, Mariaville/Otis, and Yarmouth. (In varying degrees of development.)
- Other progress includes: A Memorandum of Agreement (MOA) established with the statewide Home Visitors Network. The MFN website is updated on regular basis with local town search capability added. Parent materials have been revised based on parent input, and "Essential Elements of Local Networks" package for distribution to new networks was created. Birth data is being updated from the state monthly report for 39 existing towns in the database, new towns are added on as as-needed basis, and the data is distributed to parents in towns with active networks.
- Less-than-expected progress has been made because the Family networks are parent-organized and parent-led. Thus, network development is a constant activity with networks forming and changing as parent leadership

changes. The lead person for MFN is also Executive Director of the Maine AAP and has a demanding workload causing delays in materials development and network support. Outside consultants assist where funding allows.

Where We Want to Be

- Maine parents know how to choose and advocate for quality, affordable, consistent early care and education programs.
- Parents and their children have improved relationships with their medical homes and community schools.
- Parents learn from each other and from MFN resources better parenting skills, new child rearing methods, and child development knowledge.
- All parents feel welcomed and Parents who have functional needs and parents of children with functional needs become participants in Maine Family Networks.

WHEN

During 2008

Family networks are parent-organized and parent-led. Thus, network development is a constant activity with networks forming and changing as parent leadership changes. Throughout 2007-2009, formal connections will be made with community partners as 10 local networks occur as a result of referrals made from community partners

By 2009

Schools in network communities use MFN as link to families with newborns.

WHO LEADS

Aubrie Entwood, Executive Director, Maine AAP

Sheryl Peavey, Early Childhood Initiative (ECI) and Home Visiting Program

Burtt & Gladys Richardson, Task Force on Early Childhood

Diane Brandon, Family Resource Center Coalition

Key Partners and Collaborators with Lead Agencies
(See Table 1 in Appendix A, page 43 of this report)

How to Get There

1.1.1 Constantly expand family networks in elementary school neighborhoods in Maine as parent leaders are identified.

1.1.2 Identify free, accessible community space for parents of infants and toddlers to gather for play groups and networking activities.

1.1.3 Increase referrals to existing networks and provide MFN information that connects parents to each other, always maintaining network independence to be parent-organized and parent-led.

1.1.4 Link with local elementary schools so that schools and families with newborns develop relationship prior to starting school. MFN uses birth data lists to contact families with infants and toddlers and is a likely conduit for schools to connect with preschool children.

1.1.5 Increase links with primary health care providers such as family physicians and community health organizations, early care and education providers, government agencies, and family support and other human service providers.

1.1.6 Through communications with local network parent leaders, provide parents with information on best practices, child development specifically infant/toddler development, early intervention, school readiness, and good parenting including the importance of social emotional development of children, importance of a medical home, access to prevention and treatment of domestic violence, and access to screening for perinatal/maternal depression.

1.1.7 Provide parents with a meaningful role in the development of policies and programs at the State/local level. Increase young and first time parents' membership on Task Force.

1.1.8 Through shared information among network parents and increased access to medical homes, link parents of children with special health care needs to resources.

1.1.9 Through shared information among network parents and MFN resources, link parents to quality, inclusive early care and education settings.

1.1.10 Develop marketing strategy about Maine Family Networks to reach greater audience.

1.1.11 Connect with Family Resource Centers, particularly in York County

1.1.12 The Task Force on Early Childhood will study methods to promote and expand family networks in home visiting catchment areas by expanding home visiting staff and/or employing parents part-time.

1.2

Home Visiting Programs will deliver comprehensive, family-centered, culturally and linguistically competent, and collaborative prevention services to all communities and interested families.

Where We Are Now

- Workgroups were convened to develop Standards of Practice with representation both within home visiting and other groups. A workgroup also was convened to develop a Core Knowledge Training Plan for home visiting staff. The new Standards of Practice manual will be used to ensure statewide consistency in service delivery and the creation of more formal partnerships with local service providers. The Manual has informed rate-setting for MaineCare reimbursement to home visiting programs that will improve their capacity to serve larger numbers of families.
- The Margaret Chase Smith Policy Center of the University of Maine will help develop a funding formula for the home visiting contracts for FY '09. With current funding uncertainties, the challenge is to balance marketing with current capacity to serve.
- A detailed plan for developing an instate capacity for training all new home visitors and to provide for ongoing professional development (Core Knowledge Training Plan) is underway. The training infrastructure has been identified and contracts are being drafted to put a training team in place. As this plan evolves, potential alignments with the Maine Roads to Quality (MRTQ) training structure are being examined for efficiencies. One option under consideration is the development of a career lattice specifically for home visitors.
- The evaluation contract has been modified to become more specific in its scope with the existing contractor. Other components of evaluation (such as those related to the Touchpoints Initiative) have been moved to the expert Margaret Chase Smith Policy Center.
- Integration activities continue to expand that establish a formal relationship between the Home Visiting Program (HVP) and the Maine Immunization Program (MIP). The purpose of this collaboration is to reach new parents with immunization services information. The expertise of the Home Visiting programs has been utilized in informing the MIP's media planning for the coming year. MIP provides training and funding to the HVP.
- The Home Visiting programs have embraced the Touchpoints Initiative as recommended by the Children's Cabinet. In November, the program managers were trained by the Brazelton Institute staff and the Maine Touchpoints Training Team was identified from that group of trainees. The Training Team received their advanced training at the Institute in January and began training the home visitors across the state in March. Most of the home visitors in the state will be trained by year's end. Further training of the program managers by the Institute staff has just taken place. The Margaret Chase Smith Policy Center has begun an evaluation of the effects of the Touchpoints approach both on staff and families receiving services. A plan for FY '09 is in development to extend the Touchpoints training to other cohorts of family serving providers.
- Unmet needs as we move forward include: formal epidemiological support, financial support for a Longitudinal Study with School readiness indicators.

Where We Want to Be

Home Visitors:

1) Will serve as public health conduit for statewide preventive health initiatives and services, including the capacity to screen for Adverse Childhood Experiences (ACE) and resiliency.
2) Will ensure consistency between parents and other caregivers.
3) Are trained and meet high standards for quality and best practice including quality related to cultural and linguistic competence.

4) Will help families access appropriate early care and education and support services.

5) Have access to qualified early childhood mental health consultation.

6) Are referral source for families who have a child with functional needs.

7) Are major source for identifying babies from birth to 12 months to the CDS system and help to work out joint responsibilities.

How to Get There

1.2.1 Expand high quality Home Visiting services offering parenting information and support including work to develop outreach methods to outreach to out-of-hospital birth centers and pregnancy providers.

1.2.2 Develop fiscal plan for expansion and to serve prenatal families.

1.2.3 Address Quality Assurance/Quality Improvement.

(a) Establish core knowledge training aligned with Best Practices developed by the Home Visiting Coalition.

(b) Develop in-state training capacity including working with children with special needs. Increase IMH training opportunities for home visitors.

(c) Develop policies to ensure proactive outreach among parents and other caregivers.

(d) Develop consistent professional development standards for Maine home visitors.

(e) Conduct technical assistance site reviews with Healthy Families America state liaison.

1.2.4 Expand Touchpoints activities.

1.2.5 Work with University of Southern Maine medical/health research to secure formal epidemiological support.

WHEN
By winter 2007
Funding formula for FY 09 contracts MOU between the Office of Child and Family Services and the Maine Center for Disease Control and Prevention
By fall 2008
Fiscal plan for expansion and to serve prenatal families Develop training tract with Maine Roads to Quality (MRTQ) Home visiting Registry established with MRTQ
By fall 2009
Fund longitudinal study Develop core curriculum with Best Practices

WHO LEADS
Jan Clarkin, Maine Children's Trust
Sheryl Peavey, Early Childhood Initiative (ECI) and Home Visiting Program
Lanelle Freeman, Kennebec Valley CAP
Sheri Smith, Rob Hatch, Dora Davis, Touchpoints Training Team
Jiancheng Huang, Jeremy Black, Maine Immunization Program
Leslie Forstadt, University of Maine Cooperative Extension and Margaret Chase Smith Policy Center
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

1.2.6 Maintain database of home visit evaluations, and share with Task Force. Create database on longitudinal child and family outcomes.

1.2.7 Coordinate home visitor program with statewide cross-disciplinary training of early care and education professionals regarding balancing social/emotional and cognitive development, infant mental health, literacy, prevention of child abuse, promotion of health practices, and inclusive early education and early intervention.

1.2.8 Integrate home visiting services within the Office of Child and Family Services while maintaining connection to Maternal and Child Health.

1.2.13. Engage the Children's Cabinet in policy development to sustain and expand upon universal home visiting.

1.2.14. Finalize and implement the formal agreement (Memorandum of Understanding) between the MIP and the HVP.

1.2.15. Integrate the initiatives generated by the September 2006 Future Search Conference, "Coming Together to Create Family Centered Practice: A Future Search for Child and Family Systems in Maine," into the Maine Home Visiting System.

2. HEALTH DOMAIN

A medical home is not a physical facility. Rather, it is where parents and their children are confident that their doctor and/or nurse knows them personally and shows respect, caring, and commitment to them and their family. When a medical home is in place, parents and children trust their health provider and believe they will receive high quality, comprehensive, primary medical care and humane professional caring at all times. They become partners in decision-making. Their background, culture and language are honored. If a parent finds that these standards are not met, their concerns will be welcomed and they will be members of a team effort to improve the medical home services provided. A hospital emergency room is never a substitute for medical home care. Its use is limited to true medical emergencies when the medical home doctor is unavailable or recommends emergency services.

Maine needs new strategies to promote the importance of medical homes, medical home reimbursement within health care plans, and established best practices and protocols for medical home standards, including a focus on cultural and linguistic competence as a way to end unconscionable health disparities. We need to develop standard intake/application/enrollment forms among health care and other community services.

The focus of the Health domain will be changing the way professionals think about prevention and early intervention, evidence-based practice, and shared values and principles of practice. Maine has made significant progress in addressing access to health insurance through Dirigo/Choice coverage. Yet, access to affordable medical care and health insurance coverage remains the biggest barrier to Maine children and their families, especially among low income families and communities of color. We are also addressing established problems such as immunization, lead exposure and oral health for young children, as well as exciting breakthroughs in infant and early childhood mental health, and child care health consulting.

2.1

Health and safety programs and policies will be infused with prevention, early intervention, and care model philosophies; and with the four overarching principles of Future Search (whole system in the room, frame action within context of the whole system, focus on common ground, shared responsibility).

Where We Are Now

- Resources do not exist to review polices and practices of all providers of child and family services in Maine. The OCFS management team made the decision to address this issue with a multifaceted approach: (a) through use of the Future Search teams; (b) as new contract language was being drafted; and (c) when issues arose that spoke to specific policy barriers to seamless service delivery.

- Applied for and won a grant from the National Alliance of Children's Trust to be a pilot state for the Strengthening Families Initiative (SFI). Convened Leadership Team.
- Subcontractor developed preliminary report on training available to early care and education providers. Need to determine next steps for incorporating Strengthening Families framework.
- Brought Judy Langford, Director of the Center for the Study of Social Policy (CSSP), to Maine for series of information forums. Participated in SFI National Grantee Conference.
- Adverse Childhood Experiences (ACE) work is a priority of the Governor's Children's Cabinet, but there is a lack of clarity about how the different prevention efforts and discussions are supporting a statewide position. Co-researcher and lead physician, Vincent J. Felitti, MD, presented The ACE study at the Maine Chapter, American Academy of Pediatricians' 2006 Fall Forum and discussed Maine ACE policy with First Lady Karen Baldacci, DHHS Commissioner Brenda Harvey, and other key policy leaders.
- Resiliency: Efforts are underway, through the start-up of the Maternal and Infant Mortality and Resiliency Review (MIMRR) Program and the follow-up to the Maine AAP Fall Forum, to develop an evidence-based ACE/Resiliency screening tool.
- With a technical assistance grant, Maine hosted an EPSDT (Early Periodic Screening, Diagnosis and Treatment) forum in January 07. EPSDT oversight is currently in transition from the Office of MaineCare Services to the Division of Family Health (MeCDC).
- As result of work from EPSDT Forum, Maine applied for and won the technical assistance grant from the Commonwealth Fund for the ABCD Screening Academy pilot (15 months). This project would provide enhanced MaineCare payment to providers for screening as an adjunct to the EPSDT forms (Bright Futures).
- Maternal and Infant Mortality Resiliency Review (MIMRR): A uniquely diverse multi-disciplinary panel, including parents and communities of color, has been established. The first meeting will take place in July 2007.

WHEN

During 2008

Pilot Strengthening Families Initiative in Early Head Start and Head Start programs and incorporate Strengthening Families framework into statewide training

By fall 2008

Provide enhanced Maine Care payment to providers for the EPSDT screening.

WHO LEADS

Office of Child and Family Services Management Team (incl. Child Welfare, Early Childhood, Children's Behavioral Health)

Sheryl Peavey, ECI

Jan Clarkin, ME Children's Trust Fund

Burtt Richardson, Pediatrician

Valerie Ricker, Richard Aronson, Title V, Maine Center for Disease Control and Prevention

Melody Martin, Manager,

Office of MaineCare Services

Don Burgess, President, ME Chapter , American Academy of Pediatrics

Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

Where We Want to Be

- Maine infants and toddlers have improved physical and mental health services.
- Prenatal care and parent education programs deliver high quality, infant and toddler health and safety services.
- Concrete linkages among home visiting, CDS, Maine Family Networks, and other early childhood supports result in high quality, comprehensive services.
- Lessons learned from the two child and family related Maine Future Search Conferences (January 2005 for Early Childhood and September 2006 for family centered practice) are applied and ensure that all work that we do is rooted in Future Search Principles.

How to Get There

2.1.1. Review policies and practices of all providers of child and family services.

2.1.2. Incorporate asset-based language into policies and performance measures for prevention.

2.1.3. Explore cross-disciplinary application of the Protective Factors from the Strengthening Families framework from the Center for the Study of Social Policy

2.1.4. Review training practices mapping them to Strengthening Families framework. Obtain technical assistance and training from CSSP for "Protecting Children by Strengthening Families" framework. Seek pilot sites among child care and Early Head Start/Head Start locations for framework.

2.1.5. Support early intervention to reduce the frequency and intensity of adverse childhood experiences (ACEs) and increase and strengthen resiliency and protective factors.

2.1.6. Revise medical home intake forms for newborn and annual well child visits to include Adverse Childhood Experiences.

2.1.7. Reinvigorate and work towards consistency of EPSDT services, statewide. Incorporate standard developmental screening into primary care settings in conjunction with other child and family serving agencies.

2.1.8. Link recommendations that come from the Maternal and Infant Mortality Resiliency Review (MIMRR) Panel to the Task Force on Early Childhood.

2.1.9. Link all of the above to the efforts by Maine Title V and Maine CDC Office of Minority Health to integrate cultural and linguistic competence into all aspects of MCH policies, systems, programs, and systems.

2.1.10. Explore the success of the Juvenile Fire Setting Intervention Collaborative in York County and the viability of the Department of Public Safety's Fire Starters initiative to educate and prevent fires started by young children 5 and under.

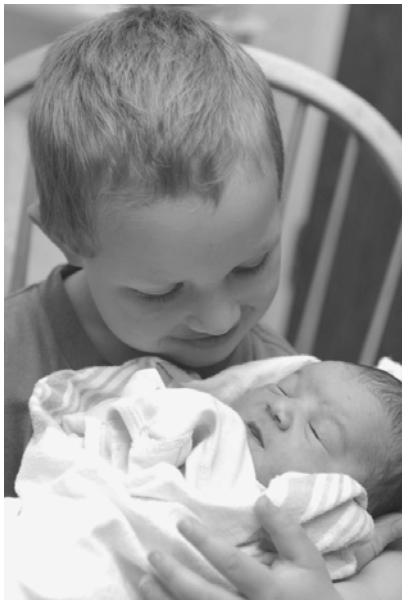
2.2

All agencies within the Office of Child and Family Services (OCFS) and the organizations with whom they work will share unified, evidence-based practices based on shared values and principles.

Where We Are Now

- Future Search teams are addressing commonalities and conflicts in beliefs and practices. Future Search has started to move dialogue and action away from an "us versus them" problem solving fix-it mindset to one that gets the whole system in the room, focuses on common ground, validates all voices, and shares responsibility and leadership.
- University of Southern Maine Muskie School of Public Service analysis of case management services overlap began Summer 06. Report out to management team expected late fall 2007.
- Work to resolve outstanding issues of confidentiality is in progress with Marina Thibeau, the DHHS liaison from the Attorney General's office.
- Sharing of client information is a focus of discussion with Child Abuse and Neglect Councils, Child Welfare Services, Home Visiting, and the Children's Trust; also by the CDS Subcommittee.
- Children's Behavioral Health Division is leading the development of an Evidence-Based Practices Advisory Council to inform state policy and payment rates for services.

- Maine was selected as a recipient of a technical assistance grant from the National Academy for State Health Policy Project, the ABCD Screening Academy, to bring best practice screening in child development, including mental health, to primary care providers' offices.
- DHHS and Univ. of Maine Center for Community Inclusion and Disability Studies (CCIDS) partnership supports the Child Care+ME (CC+ME) project to improve the quality of child care, expand access to child care and prevent the expulsion from child care for children at risk and children with identified disabilities or other special needs. The project has developed a model for providing professional development and consultation including early childhood mental health consultation to early care and education programs and professionals.



- The Office of Child and Family Services Early Childhood Division has supported the development of a Technical Assistance (TA) pilot network to coordinate consultation to child care providers in the state. Partners working on this pilot include three RDC sites, CCIDS/CC+ME project staff, MRTQ accreditation staff, Head Start Region I Quality Initiative consultants in Maine, DHHS Infant Toddler consultant, and the DHHS After School Network consultant. The goal is to provide a seamless TA system to early care and education providers.
- CC+ME project included funding in FY 2006-07 for CCIDS to develop and implement a 22 hour Leadership Institute on Foundations of Consultation as a result of a recommendation from the TA pilot network. The curriculum includes emerging evidence related to core competencies needed to provide effective consultation (process and subject expertise). Participants invited included all TA pilot professionals as well as all RDC Directors and educational specialists.

Where We Want to Be

- All administrative systems reflect unified, evidence based practice guidelines and Future Search principles.
- There is no unnecessary duplication among case management, treatment, consultation, professional development, and other support services within Office of Child and Family Services programs and services.
- Quality assurance is aligned for care management, treatment, consultation, professional development, and other support services.
- A cross-disciplinary understanding of child development, inclusive education/disability studies, early childhood/infant mental health, literacy, and cultural and linguistic competence exists among all service providers and professionals.
- Consistent minimum qualifications and core competencies for case management and consultants aligned with practice guidelines is the norm.
- There is common HIPAA acceptable information sharing.

WHEN
By Fall 2008
Administrative systems are revised, services' implementation and outcomes are monitored, and duplication among services is reduced
By 2009
Issues of integration with respect to confidentiality, multiple eligibility and payment conflicts are resolved

WHO LEADS
Office of Child and Family Services Management Team
Office of Attorney General
DHHS/DOE Interagency Workgroup
Office of MaineCare Services
Maine Children's Alliance
ACCESS
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

How to Get There

2.2.1 Develop unified, evidence based practice guidelines.

2.2.2 Develop interdisciplinary work group.

2.2.3 Identify commonalities and conflicts in beliefs and practice models.

2.2.4 Revise administrative systems requirements.

2.2.5 Monitor implementation and outcomes of services.

2.2.6 Adopt current health care industry practice for targeted case management.

2.2.7 Reduce duplication among case management, treatment, consultant, professional development, and other support services within Office of Child and Family Services services.

2.2.8 Enable effective and efficient transition among case management, treatment, consultation, and other support services for which Office of Child and Family Services has direct or oversight responsibility, while eliminating any unnecessary duplication with any one family.

2.2.9 Work to resolve outstanding issues of confidentiality in order to expedite referral and delivery of appropriate services, and ensure that the process of sharing client information guarantees consumer rights to choice and to informed consent.

2.2.10 Clarify eligibility and payments between MaineCare, Part C, IV-E, Title V, EPSDT, etc. when children have multiple eligibility status.

2.2.11 Consult with the Future Search Network (FSN) to ensure that Future Search Principles are woven into all activities.

2.3

A coordinated system of early childhood/infant mental health training resources will be developed for professionals working with children and their families.

Where We Are Now

- Several groups are looking at the need for early childhood and infant mental health services on various fronts. Coordination across disciplines is essential to successful service delivery.
- Home Visiting has training requirement to specifically include Infant Mental Health.
- Evidence Based Practices (EBP) Advisory Council now meeting regularly to develop list of practices that can be prioritized as a MaineCare benefit.
- Planning underway to make three-day infant mental health training available to all child and family serving agencies.
- Margaret Chase Smith Policy Center is developing Infant Mental Health workforce report.
- An approach to providing child care mental health consultation developed by CCIDS through the CC+ME project includes specific planning, development, training, and consultation activities to expand early childhood mental health consultation. A unique feature of the pilot is the inclusion of area mental health clinicians and the focus of building their capacity to provide both individual and programmatic consultation to children, families and staff in child care. CCIDS staff coordinated and provided the professional development/consultation. In addition to sustaining current activities and /or replicating this model, there continues to be a need to coordinate with other existing resources (CC+ME and other TA pilot consultants) and to explore issues around billable

hours and costs. Coastal ELOA, providing child care mental health consultation in the Midcoast area, is using elements of this approach.

- There are pilots in the Lewiston area where infant mental health specialists are placed in pediatric offices and rural health clinics.
- Currently, the Governing Council of THRIVE (the Trauma Informed System of Care project) is exploring incorporating the Infant Mental Health Training and Child Parent Psychotherapy as an evidence based practice particularly for children under five.
- Office of Child and Family Services single system of Children's Behavioral Health Services workplan has been developed.
- CC+ME Project provides professional development and consultation to early care and education providers and other system partners to prevent the expulsion of children with challenging behaviors or those with diagnosed mental health issues from child care.

WHEN
By fall and winter 2007
Infant Mental Health and Child Parent Psychotherapy incorporated as evidence based practice for children under five.
By 2009-2010
Childhood/infant mental health specialists will be in doctor's offices/health clinics.

WHO LEADS
Jane Weil, Mark Rains, Maine Assn. for Infant Mental Health
Karen White, Infant/Toddler Initiative DHHS
Ann O'Brien, Children's Behavioral Health Services, OCFS
Jen Maeverde, UM-CCIDS
Alan Cobo-Lewis, UM Psych. Dept.
Deb Hannigan, Child Development Services
Michele Pino, Head Start
Allyson Dean, Maine Roads to Quality
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

Where We Want to Be

- Universal social/emotional developmental screening exists for all young children that is culturally and linguistically competent and designed to end health disparities.
- High quality, appropriate, family-centered childhood/infant mental health screening and appropriate referrals are provided to all at-risk children, all children ages birth to 3 years entering the foster care system, and all children eligible under IDEA Part B (619) and Part C.
- Cross-disciplinary understanding of child development, inclusive early education, mental health, literacy, and other pertinent children's issues is pervasive.
- Family-centered, community-based, respectful, and culturally reinforcing childhood/infant mental health services exist in Maine.
- Common HIPAA Approved Information Sharing Process for coordinated collaborative care.
- Greater parent involvement in mental health interventions.
- The Child Development Services system screens for social/emotional development from birth to age five and refers children for Infant Mental Health assessment and develops treatment plans with community providers.
- Pre-K programs screen, assess and seek childhood mental health treatment services.

How to Get There

2.3.1 Place childhood/infant mental health specialists in pediatric offices, rural health clinics, etc.

2.3.2. Itemize and improve training resources, develop common language, and reduce disparities related to children's social, emotional, and behavioral health.

2.3.3. Integrate and formalize ongoing professional and workforce development for Childhood/Infant Mental Health providers.

2.3.4. Locate financial support for Childhood/Infant Mental Health training through the Resource Development Centers (RDCs)

2.3.5. Incorporate evidence-based professional development models with multiple methods of gaining knowledge and skills and opportunities for ongoing collaborative inquiry. The models are useful, offer standards, follow-up, and evaluation. Confirm common and evidence-based training modules for each group.

2.3.6. Catalog currently trained groups in childhood/infant mental health and estimate potential audiences (i.e., child welfare, Head Start, public health nurses).

2.3.7. Outline plan to provide DC 0-3 training statewide.

2.3.8. Get childhood/infant mental health trainers registered with Maine Roads to Quality to augment childhood/infant mental health training for early care and education providers.

2.3.9. Draft childhood/infant mental health workforce report for community college system (to include labor trends, salary, etc). Explore addition of childhood/infant mental health training through the RDCs ($6K to each RDC for 2 IMH trainings x 8 RDCs = $48,000).

2.3.10. Expand the current early childhood mental health consultation provided through the CC+ME Project and the model piloted through the Coastal ELOA project in the Midcoast area by replicating the activities in other regions and continuing the consultation developed in the Midcoast area.

2.3.11. Bring child care mental health consultation to early care and education and child and family service providers, statewide. Professional development and training should be consistent, accessible, and inclusive, and supported by evidence based practice and Maine-based research (CC+ME project, Coastal ELOA project, etc).

2.3.12. Define, plan, train, and implement collaborative and comprehensive Trauma Informed System of Care with the aim to prevent, recognize trauma, and intervene early and effectively in Franklin, Oxford, and Androscoggin counties.

2.3.13. Support implementation of the OCFS Single System of Children's Behavioral Health Services Workplan

2.3.14. Integrate Evidence Review Process for Early Childhood: (a) choosing diagnoses/issues that need attention; (b) selecting most effective treatment intervention; (c) addressing barriers to implementation; and (d) measuring outcomes.

2.3.15. Explore the feasibility of more early diagnostic clinics for autism spectrum disorders.

2.3.16. Contract with Maine Association for Infant Mental Health (MeAIMH) for a position paper.

2.4

All Maine children at risk for lead exposure will receive adequate, appropriate risk assessments, screening tests and follow-up care.

Where We Are Now

- *Community Mobilization/Working with landlords*: Developed Myths v. Facts Info Sheets. Millard Rackliffe, president of Maine Apartment Owners and Management Association attended recent LEAd-ME (Childhood Lead Poisoning Prevention Advisory Council) meeting. Seemed willing to work with us on a number of fronts. MAOMA has their annual conference in October; Millard is coordinating with Carole Cifrino from DEP to have a lead display and workshop on lead. Millard also works on the MAOMA newsletter and seemed interested in an article on lead, so there may still be an opportunity to place the fact sheet in the MAOMA newsletter. Finally, DEP will work with Millard to explore the possibility of offering Lead-Smart Renovator classes for landlords and maintenance crews.
- *Outreach to communities:* Real opportunity lies with the new Lead Poisoning Prevention Fund (LPPF). A key component of the LPPF will be grants to high-risk communities. RFP will be issued through the new public health infrastructure. MaryAnn Amrich, Program Manager, will be approaching the LEAd-ME council in the fall to initiate discussions about what we would want the communities to do/what specific outcomes we would be looking for. Community Mobilization workgroup can help initiate community grants.
- LEAd-ME meetings: It has been challenging this year to find meeting dates that work for everyone. Now have website that helps send out calendars through the LEAd-ME page.

Where We Want to Be

- All providers at child and family system points of entry (including WIC, Head Start, child care, CDS, CBH, CPS, Healthy Families, public Pre-K) will understand how to assess for lead exposure risk in young children and agree to routinely assess and encourage lead screening
- All pediatric health care providers and prenatal health providers will understand lead exposure risk in young children and agree to routinely encourage lead screening.
- All child and family system points of entry will serve to routinely screen and/or refer families for lead exposure.
- All lead poisoned children will receive long-term follow up assessments and interventions through the school system and developmental services agencies.

How to Get There

2.4.1 Develop message for health care providers and parents addressing Lead Poisoning myths, so they understand that lead poisoning is still a problem in Maine; that the risks of lead exposure are not specific to one demographic (or income); that lead screening and its results are helpful (not harmful) to the living environments of young children.

2.4.2 LEAd-ME and partners will identify barriers to screening (with data from such sources as MaineCare, DOE, DEP and local communities) and plan to address those barriers (such as billing). This includes reviewing Maine laws impacting lead-safe housing and identifying gaps in housing laws and policies.

WHEN

By Fall 2008

All pediatric health care and all providers at child and family system points of entry will understand how to assess for lead exposure risk, routinely assess, and encourage lead screening.

By 2010

All child and family system points of entry will routinely screen and refer families for lead exposure.

WHO LEADS

Mary Ann Amrich, Childhood Lead Poisoning Prevention

Alfred May, Environmental Health Epidemiologist

Bob Dodd, Maine Lead Safe Kids Fund, Coalition for Environmentally Safe Communities

Sheryl Peavey, ECI

Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

2.4.3 LEAd-ME and Office of MaineCare Services will develop system to identify Medicaid-enrolled children who are not receiving a blood lead screening test. Incorporate blood lead screening information into the state IMMPACT system for immunization registration.

2.4.4 Train Mental Health Providers to include lead poisoning in their differential diagnosis of early childhood behavior problems.

2.5

Improve and expand existing Child Care Health Consulting Services.

Where We Are Now

- Child Care Health Consultation (CCHC) Training offered each fall in Maine in coordination with New England Healthy Child Care Coalition using technology and video feed.
- NAEYC Accreditation Guidelines increase need for more health consultants.
- All Head Start Agencies have full-time health consultants.
- Medication Administration curriculum developed as a joint project of the Department of Education (DOE) and the Office of Child and Family Services Early Childhood Division/Child Care and Head Start. Training on Medication Administration offered annually.

- Data base of child care health consultants developed.
- In conjunction with other New England offices, Maine worked on State and regional development of mental health component.
- Early Childhood Comprehensive Systems grantees in Region I (New England) have been working together to offer trainings concurrently using technology and video feed.
- Explore pooled funding from sources such as Immunization and Lead and Oral Health.
- We have supported the development of a technical assistance pilot network to coordinate consultation to child care providers. Child Care Health Consultants should be linked to this network.

Where We Want to Be

- Child Care Health Consultants are in all child care centers and available to all family child care providers.
- Providers are proficient in Health and Safety Standards. Quality Early Care and Education Standards include Health and Safety and caring for children with special health care needs or disabilities.
- Child Care Health Consultants participate in the DHHS Technical Assistance pilot network and receive same core consultant training and ongoing professional development with other consultants.
- Parents are included in assessment and consultation process.

WHEN

By 2009-2010

Child Care Health Consultants are available to child care providers.

WHO LEADS

Carolyn Drugge, Erika Leonard, Sheryl Peavey, Early Childhood Division, OCFS

Immunization and Oral Health programs, Maine CDC

Janine Blatt, DOE

Bob Steinberg, Child Care Licensing

Maine Child Care Advisory Council

Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

How to Get There

2.5.1 Create/fund State CCHC Coordinator.
2.5.2 Build a network of child health consultants linked to the public health districts and the Child Care Resource Development Centers.
2.5.3 Expand network of child care health consultants with childhood/infant mental health expertise.
2.5.4 Explore pooled funding from sources such as Immunization, Lead, and Oral Health.
2.5.5 Establish state CCHC certification and pay scales.
2.5.6 Expand training on medication administration guidelines.
2.5.7 Revise the *ABC's of Safe and Healthy Child Care* and distribute**.**
2.5.8 Make current regional training flexible and cost effective.
2.5.9 Explore loan forgiveness, certification and other incentives to increase CCHCs.

2.6

All children in Maine are routinely immunized.

Where We Are Now

Maine immunization rates dropped significantly during the late 1990s and the early 2000s (from 95% to 87%); however rates have begun to increase. The Maine Immunization Program believes that the increased rates are due, in part, to expanded program partnerships. A strong collaborative relationship has been developed with the State Immunization Program (MIP) and the Office of Child and Family Services. The MIP is a new but actively involved participant in the Task Force on Early Childhood and will partner with the Early Childhood Division in the support of the Governor's Summit on Early Childhood. Training is provided by MIP staff to the Home Visiting Program.

Where We Want to Be

Immunization services are priorities for all child and family service providers.

How to Get There

2.6.1 Develop a comprehensive immunization strategic plan that outlines priority areas and placement of resources.

2.6.2 Insure integration of immunization services priorities for all child and family services providers.

2.6.3 The MIP Management Team, along with Early Childhood partners will expand a process that to create a state-wide regional presence for MIP activities; particularly for health education and provider education.

2.7

More Maine children birth to 3½ years will receive comprehensive, preventive oral health care.

Where We Are Now

- HP 2010 Grant awarded in spring 2007 ($20,000 for two years) to AAP, Maine Chapter
- Dental Access Coalition developing workplans for implementation of strategies (summer 07).
- Partnership between home visiting and early Head Start is established to provide dental care for pregnant women in Kennebec County.
- Funding provided from Sadie and Harry Davis Foundation to five (5) diverse sites effective July 2007 for two years. Further funding via competitive process expected after 18 months.
- Maine Oral Health Program and the Office of Rural Health and Primary Care are co-managers of federal grant supporting efforts in dental workforce recruitment, training of dental & non-dental health professionals, and promotion of dental careers to young people.
- Head Start Oral Health Forum held and Oral Health Plan developed.

Where We Want to Be

- Policymakers believe that oral health is a priority for Maine's children and understand that children in many areas do not have access to quality oral health services and supports.
- It is widely understood that all parents want dental care for their children.
- Maine's children have reduced incidence of dental disease through improved oral health services and supports.
- At eruption of first tooth, children are seen by a dental professional.
- Children with disabilities in all areas of the state have access to dental care.

WHEN

By Fall/Winter 2007

Write report on dental shortage areas, child impact, children with special health needs.

By 2008

Fund more diverse sites to deliver oral health care

By 2009

Enhance workforce recruitment, training of dental professionals, and promotion of dental careers by 25%

By 2010

Provide early preventive oral care to 50% more children birth to 3 ½ years in a range of health care settings

WHO LEADS

Judy Feinstein, Maine Oral Health Program, MeCDC

Michele Pino, Head Start Directors Association

Maine Dental Access Coalition

Toni Wall, Children with Special Health Needs, MeCDC

Maine Children's Alliance

Charles Dwyer, ME Office of Rural Health and Primary Care

Aubrie Entwood, MAAP

Mobile Dental Programs (Sherri Camick/Theresa Alley from Tooth Ferry)

Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

How to Get There

2.7.1. Work with the Maine Chapter, AAP, as it commences its HP 2010 grant, "Oral Health Risk Assessment in the Pediatric Practice."

2.7.2. Engage Early Head Start personnel in early oral health risk assessment training ("Lunch and Learn" Sessions).

2.7.3. Follow progress of intensive training with pediatric practices including a "review" of the information or support provided related to care for children with disabilities.

2.7.4. Refine/adapt lessons learned into model training program for early care and education providers focusing on oral health early intervention, prevention and referral.

2.7.5. Use dental hygienists from innovative Office of Oral Health and speech therapists programs to provide training; build it into grant funding.

2.7.6. Advance the State Oral Health Improvement Plan.

2.7.7. Tell the story behind the numbers and clearly explain the issues beyond federal dental shortage areas. Identify barriers such as long wait lists, great distances, and dentists only willing to provide simple procedures and how this affects children with special health needs. Eradicate fallacy that parents don't want dental care for their children.

2.7.8. Obtain baseline data and generate report on birth to 5 child access to comprehensive oral health services. Use Head Start/Early Head Start PIR data to understand what areas have the largest gaps between the number diagnosed as needing dental services and the number getting services. Share report with Task Force on Early Childhood, Children's Cabinet, Legislators, and public.

2.7.9. Increase public awareness of the importance of oral health to overall health and development and the relationship to speech development.

2.7.10. Develop plan to expand prevention and treatment programs through policy change.

2.7.11. Promote dental care for pregnant women by replicating partnership model between home visiting and Early Head Start (MOU, crosswalk to Head Start requirements via Home Visiting prenatal curricula).

2.7.12. Add Oral Health indicator in Home Visiting performance measures (via Home Visiting Tracking System).

2.7.13. Explore expansion of oral health data in Kid's Count.

2.7.14. Support and promote other initiatives that focus on early preventive care, capacity-building, and infrastructure development as a means to support oral health.

2.7.15. Promote the work of the Sadie and Harry Davis Foundation in its goal to provide early preventive oral care to children (birth to 3½) in a range of health care settings.

2.7.16. Engage state leadership in work around oral health workforce development (in conjunction with state Oral Health Program & ME Office of Rural Health & Primary Care), particularly through the Children's Cabinet.

2.7.17. Include oral health as a function of the child care health consultant in public health district offices.

2.7.18. Ensure that special populations have access to quality oral health to include children in foster care and children with disabilities.

3. EARLY CARE AND EDUCATION DOMAIN

Quality, effective early childhood experiences serve as a foundation for life long learning. For the past decade or more, research into the way an infant brain develops has been the focus of quality improvements in early childhood programs. Finally, modern neuroscience has provided the proof to support what early childhood experts have long believed--that early childhood education, nurturing, and high quality care is key to a child's success later in life.

Quality, affordable early care and education is integral not only to the lifetime success of Maine's children but to the economic development of the state. It prepares the future workforce and enables parents to support their families. The working parent is an integral and essential component of the Maine workforce. The gap between the cost of living and family income and other economic pressures have not only increased the number of families needing child care in order for parents to work, it has also decreased the number of friends and relatives ("informal" providers) able to care for these children.

Further complicating the early care and education issue is the fact that quality care and education costs! And this cost is borne primarily by the family leading to overall low wages of child care workers in spite of the ever-increasing high cost of care. Early care and education is a labor intensive industry, with high overhead costs such as benefits, mortgages, and utilities often passed onto the provider to absorb. To many Maine families, child care expenses have become the second most significant family expense following the mortgage or rent often costing as much as tuition to the University of Maine.

Yet, available spaces in formal child care programs, adequate child care subsidies for low income children, and limited quality in the majority of Maine programs create serious obstacles for Maine's families and their children. Infants and toddlers, children with special needs and low-income working families face even more complex challenges to high quality care.

3.1

Maine children will have access to quality, affordable, accessible early care and education programs.

Where We are Now

Currently, Maine has licensed slots for only 28% of the children in need of out of home care and less than 4% capacity in Maine's Program of Quality which issues Certificates of Quality.

Maine's own recent "Cost/Quality Studies" of child care demonstrated that: (1) Increased quality of care increases the positive outcomes for children, (2) the quality of care in legal and licensed facilities varied tremendously, and (3)

there is a clear correlation between the cost of care and the quality of that care (primarily in the increased cost of training and retaining direct care staff.) By Maine's estimates, there is subsidy funding for approximately 40% of Maine eligible children.

Driven primarily by the laudable increase in standards, the cost of care for Child Care in Maine has increased by a factor of between 18% and 26% over a four year period. In spite of the increased need (reflected both by increased numbers of working families and the greater understanding of the importance of the early years) public investments to support the young Child and the working family have actually decreased in Maine, reflected both in state and federal budgets.

Maine has made progress in recent years, despite limited resources. Maine has the knowledge and the know-how to improve quality in Maine's early care and education programs and to assist parents in paying for quality child care. State leaders have supported several critical activities in recent years. They include:

- *The Maine Early Childhood Learning Guidelines* (ELG) provides guidance to promote learning opportunities for all children in state-funded Pre-K, Head Start, child care centers, family child care homes, and nursery schools.
- *Maine Roads to Quality (MRTQ)*, the Early Care and Education Career Development Center within the Muskie School of Public Service at the University of Maine.
- *The Accreditation Facilitation Project* provides financial support and technical assistance to licensed family child care providers and child care centers in Maine who wish to seek national accreditation. (Currently, 76 child care centers/49 family child care providers.)
- *The Maine Roads Scholarship Program* provides financial assistance to child care providers pursuing degrees.
- *The Core Knowledge Training* offers 180 hours of approved training in specific core knowledge areas. (107 individuals completed the 180 hour Core Knowledge Training)
- *The Maine Roads Registry and Career Lattice* is Maine's child care and early education professional recognition system.
- *Maine's Resource Development Centers* are an all-in-one resource for child care throughout Maine's 16 counties, helping over 4,000 families find, evaluate, or pay for child care each year, and approximately 350 new child care providers go into business. In FY 2004, 1,638 early care and education professionals received 37,502 hours of core knowledge training.
- *Maine's Infant and Toddler Initiative* works to improve the quality of infant and toddler care.
- *Child Care Plus ME* is a collaborative partnership between the University of Maine's Center for Community Inclusion and the DHHS to offer problem solving assistance and training in working with children with special needs.

WHEN
By Legislative Session, 2009
Fund initiative to increase licensed, quality child care, improve quality of existing programs, advance caregiver education and compensation, and assist parents in paying for child care.

WHO LEADS
ACCESS
Maine Child Care Directors Assn.
Maine Family Child Care Association
Maine Roads to Quality
Early Childhood Division, OCFS
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

Where We Want to Be

- Children: Opportunities for improved educational success
- Families: Quality, accessible, inclusive, consistent, affordable early care and education available to all young Maine children
- Business: Reduced workforce absenteeism and turnover and increased productivity and businesses engaged in planning for increased quality care

- Providers: Improved quality and satisfaction, increased professional development, better compensation and benefits
- Government: Reduced remedial services and expense
- Educational System: Children enter kindergarten ready to learn and succeed, graduate on time, and advance through higher education
- Health Care System: Prevention of illness, promotion of health and safety, reduced obesity/smoking
- Communities: Healthier citizens, fewer dropouts, less crime and delinquency.

How to Get There

3.1.1. Increase access to early care and education programs for Maine's working families so that the "cost of care" is not a barrier to families accessing quality child care by (a) increasing child care subsidies for low to middle income working families (b) increasing participation in Head Start/Early Head Start, (c) increasing access to programs caring for infants, toddlers, and at risk children, (d) developing funding streams for the gap between true cost of quality care and parents ability to pay, (e) addressing other funding gaps, (f) increasing funding/eligibility for financial assistance programs, and (g) insuring that the systems administering child care subsidies are designed to allow and encourage families to access the highest quality child care available.

3.1.2. Increase the number of licensed early care and education programs.

3.1.3. Increase the number of early care and education programs that are inclusive of all children regardless of special needs.

3.1.4. Improve child care facilities through a facility bond package for no- and low interest loans for ECE programs.

3.1.5. Remove some of the limitations on the child and dependent care tax credits available to Maine families.

3.1.6. Provide tax-based incentives for employers who choose in invest in the child care needed by their employees.

3.1.7. Provide funding for a variety of community-based programs intended to raise the quality of care for all children, including children with special needs.

3.2

Maine will have a stable, qualified high quality early care and education and home visiting workforce.

Where We Are Now

Research informs us that there is no greater determinant of quality outcome for the young child than the quality of the adults working with those children. Training, intentionality, and tenure are the three equally important components of quality required of early care and education workforce. The systems that we develop in response to the needs of the young child must address all three of these concerns. The barriers to meeting this need go beyond the availability of training opportunities to the need to increase wages and the availability of fringe benefits to this workforce.

Even though Maine is in the top 12 in the nation in child care salaries, the child care workforce is lowly paid, has few benefits, and is under-educated. It is not surprising that more than 25% of them leave the job every year--a disrupting factor for very young children who need consistent caregivers in their lives. However, this is down by 6% from 2002 when 31% of the teachers left the classroom. Like the rest of the nation, the majority of Maine child care teachers do not have a four year college degree: 31% have a Bachelor's degree, 22% have a two-year

Associate's degree, and 50% have only a high school diploma. About 64% of the family child care workforce has only attained a high school diploma or GED--only 12% have a Bachelor's degree.

Maine's average child care teacher salary is $18,862. Family Child Care Providers have an average annual income of $26,836. As a workforce, child care providers rank number 596 out of 647 detailed occupations, according to the Maine Department of Labor (Mean hourly wage of $9.42). That means that 595 other Maine occupations are paid more than child care workers, such as Manicurists and Pedicurists ($9.72) or Animal Trainers ($15.55).Head Start Education and Training Standards for classroom teachers have increased, however, funding to meet these new standards has not kept pace.

Accreditation Standards developed by the National Association for the Education of the Young Child has also increased requirements for child care teachers, however public funding for child care has not increased and parent disposable income available to pay for this child care has also decreased (when adjusted for cost of living) in Maine over the past 7 years. Employee benefit costs, a primary component of tenure, has increased dramatically over the past 10 years.

Where We Want to Be

- Early care and education programs and home visiting services employ highly qualified, skilled, educated, experienced, and committed personnel at all levels.
- Salaries in the early childhood field are commensurate with the grave responsibilities for children and their families, with the amount of education and training required, and with the value that Maine's citizens places on their youngest children.

How to Get There

3.2.1 Conduct cost benefit analysis to improve compensation and benefits.

3.2.2 Report on disparities among early care and education providers including home visitors and Head Start and public school Pre K teachers.

3.2.3 Using the Maine Roads to Quality Registry, establish and align qualifications and competency benchmarks for ECE providers.

3.2.4 Enhance the education opportunities for Maine's early care and education professionals through scholarships for child care providers seeking higher education, and create a post secondary curriculum for those working with pre-school children with special needs. Provide free and low cost training and education opportunities for the early childhood professions.

WHEN
By winter 2007
Cost-benefit analysis
By spring 2008
Increase training, TA Develop Competency benchmarks More accessible degree programs
By Legislative Session, 2008
Fund initiative to increase licensed, quality child care programs, improve quality of existing programs, advance caregiver education and compensation, and assist parents in paying for child care.

WHO LEADS
Patti Woolley, Early Childhood Division
Rita Fullerton, RDCs
Lu Zeph, CCIDS
ACCESS
Pat Ende, Governor's Office
Janine Blatt, DOE
Bob Steinberg, Child Care Licensing
MSEA-SEIU
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

3.2.5 Look at Strengthening Families and/or Touchpoints competencies for providers and crosswalk them with the core knowledge training curricula.

3.2.6 Offer coordinated, multi-level technical assistance aligned with other forms of professional development to providers as they work toward higher level of quality.

3.2.7 Support the continuation of ongoing professional development and communities of practice support for early childhood, mental health, health, and early childhood special education /early intervention consultants statewide. For instance, the Infant Toddler Professional Development Team has outlined certification levels for specialty training and credentialing for working with infants and toddlers; level one curriculum is

complete and can begin by spring 2009; curriculum needs to be developed and approved by the higher education board for the upper two levels.

3.2.8 Formalize the in-service training of technical assistance consultants (TA) currently being provided and develop competencies toward a certificate or credential for TA profession.

3.2.9 Develop public information campaign with focus on disparity in compensation and quality and stability of workforce.

3.2.10 Address insurance barriers for family child care providers. Explore Dirigo Choice for ECE providers.

3.2.11 Create more accessible degree programs. Inform early care and education professionals of "Educators for Maine Loan Forgiveness Program."

3.2.12 Increase wages/income for four year Early Childhood degree graduates who work in field for 5 years or more.

3.2.13 Explore modifying MaineCare payment regulations to address the holistic needs of infant mental health providers, thereby meeting more of the need for the IDEA required services in the social/emotional domain.

3.3

All children and their families will have increased access to quality early care and education programs through the implementation of a Voluntary Quality Rating System (QRS) that increase the quality of programs through system-wide improvements.

Where We Are Now

- Focus groups with parents and providers held statewide to collect input on quality indicators.
- QRS being piloted and data collected. Indicators will be validated through research.
- The MRTQ Provider Registry is aligned with QRS requirements
- On-line application and resources developed. Data from Registry will be used to verify professional development levels.
- Technical Assistance System developed; training in Collaborative Consultation was held.

Where We Want to Be

- Parents will have increased understanding of high quality early care and education and will demand high-quality care be provided to their children.
- Increased professional development of early childhood workforce.
- Increased quality of early care and education programs.

How to Get There

3.3.1. Implement QRS statewide (have finished paper based pilot, now testing e-pilot)

3.3.2. Develop plan to provide incentives for programs at each level. Link financing and supports to quality.

3.3.3. Market QRS to providers and parents.

3.3.4. Create alignment between licensing, subsidy and quality across child care, Head Start, and pre-K.

WHEN
By 2008
Implement QRS statewide. Provide incentives for providers
By 2009
Evaluate use of incentives, use of training, and community comprehension

WHO LEADS
Erika Leonard, Early Childhood Division
Maine Roads to Quality
Resource Development Centers
Child Care Plus ME
ME Child Care Directors Assn
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

3.3.5. Increase available training on "Implementing the Maine Early Childhood Learning Guidelines" and "Supporting Maine's Infants and Toddlers: Guidelines for Learning and Development."

3.3.6. Develop learning tool to help parents understand infant and toddler development and the infant and toddler guidelines.

3.3.7. Disseminate tool to pediatricians, home visitors, Maine Family Networks, and all early care and education providers.

3.4

All children and their families will have access to comprehensive, quality, coordinated and integrated services in all public and private early care and education settings.

Where We Are Now

- Maine Interagency Funding Collaborative Task Force developed publication " Funding Collaboration Guide for Early Care and Education Partnership in Maine" to provide guidance for developing community based collaborative early care and education programs.
- Developing formal MOU between DOE and DHHS.
- Interagency group is meeting with leadership from Governor's Office
- Pre K Now funding secured, Pre K Standards being developed.
- LD 560 (PL 2007, c. 141) signed into law to distinguish Four-Year-old programs as separate from Two-Year Kindergartens in statute.
- Four Year Old Resource Group has been meeting for nearly two years. Hosting regional forums. First Forum hosted in October 06 in Gray; second Forum in May 2007 (Bangor); third Forum in May 2007 (Machias); and final Forum in Oct 07 (Aroostook)
- Summarizing Maine Forums, what is currently in place and strategies to move forward.

Where We Want to Be

- Early care and education settings offer quality, comprehensive services integrated with other appropriate early childhood services that meet the needs of working parents.
- Child and family serving professionals will be cross-trained in child social-emotional and cognitive development and literacy disciplines.
- All children, including those with special needs/special health care/behavioral health needs, will have access to high quality inclusive early care and education programs.
- Have HIPAA approved process for information sharing

How to Get There

3.4.1. Identify and address changes in policy, accountability, quality assurance, and funding for services in early care and education settings.

3.4.2. Continue implementation of Early Learning Guidelines for early care and education community providers and public Pre-K.

3.4.3. Seek input from stakeholders including Child Care Advisory Council, Four Year Old Resource Group.

3.4.4. Support coordination of all early care and education programs with CDS, Children's Behavioral Health, Child Welfare services, and more with vigilant consideration of the context of Maine families' economics.

3.4.5. Seek ideas from other states with strong Pre K programs on how to bring early childhood staff employed by pubic schools, non-profits, Head Start, private schools and programs, and others together as colleagues.

3.4.6. Identify funding sources and existing resource opportunities aligned across systems.

3.4.7. Establish a system of accountability between DOE and DHHS.

WHEN
By October 2007
Final regional Pre-K public forums held. Pre K Standards completed.
By Summer 2008
Pilot Collaboration Coaching Model Compile report on Pre K Forums with strategies to move forward

WHO LEADS
Patti Woolley, Sheryl Peavey, Carolyn Drugge, Early Childhood Division
Janine Blatt, Jaci Holmes, DOE
ME Child Care Advisory Council
Karen White, Infant Toddler Initiative
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

3.4.8. Formalize Four Year Old Programs as critical component of early care and education delivery system.

3.4.9. Compile report on viable Pre K strategies and options.

3.4.10. Pilot the Collaboration Coaching Model. Align the collaborative coaching model with the other initiatives currently implemented within the state including the work to connect and coordinate consultation through the DHHS supported TA pilot network.

3.4.11. Develop HIPAA approved process for information sharing.

3.5

Child Development Services will meet the cognitive development and the social, emotional and physical needs of young children in Maine.

Where We Are Now

- Established Subcommittee to Study Early Childhood Special Education with independent facilitation by Vicki Hornus, Northeast Regional Resource Center, VT, provided by DOE.
- Examined the efficacy and compliance of the current system for early intervention and early childhood special education and the ability of the current early childhood system to strike a reasonable balance among the cognitive development and social, emotional and physical needs of young children.
- Completed Report on Early Childhood Special Education. Reported out to the Task Force on Early Childhood, the Children's Cabinet, and the Health and Human Services and Education/Cultural Affairs legislative committees. Report available at DOE Website: http://www.maine.gov/education/speced/cds/committee/finalreport.pdf
- LD 1850 passed and signed as amended (PL 2007, c. 450) to enact many of the recommendations of the Task Force on Early Childhood Subcommittee to Study Early Childhood Special Education Services from Birth to Age Eight.
- DOE/CCIDS partnership agreement (LEARNS Project) is conducting research related to (1) the achievement of a comprehensive program approval process of birth-5 special services; (2) the achievement of a data collection system for a Pre-K-CDS pilot site that will inform the program approval process; and (3) the provision of

training related to new IDEA regulations and State law to a wide range of professionals, parents, foster parents, caseworkers related to young children with disabilities birth-5.

Where We Want to Be

Re-establish Child Development Services as one of Maine's major Early Care and Education systems.

How to Get There

3.5.1 Acknowledge that the Child Development Services (CDS) program, its staff, and its clients have been through a difficult 2-3 years fraught with unknowns and disagreements about how to design/develop, fund, and implement the program across the state.

3.5.2 Bring CDC components together with its Early Care and Education partners by county or regionally.

3.5.3 Emphasize CDS role with social/emotional and/or with substance-effected infants/children, children who are homeless, and with children in foster care.

3.5.4 Re-establish a strong CDS training component.

3.5.5 Develop new and stronger Memorandum of Understanding between DOE and DHHS.

WHEN

By 2008

MOU between DHHS and DOE completed
Training re-vamped
Program strengthened (not dismantled)

WHO LEADS

Jaci Holmes, Deb Hannigan, David Stockford, DOE

Education and Cultural Affairs Committee

Lu Zeph, CCIDS

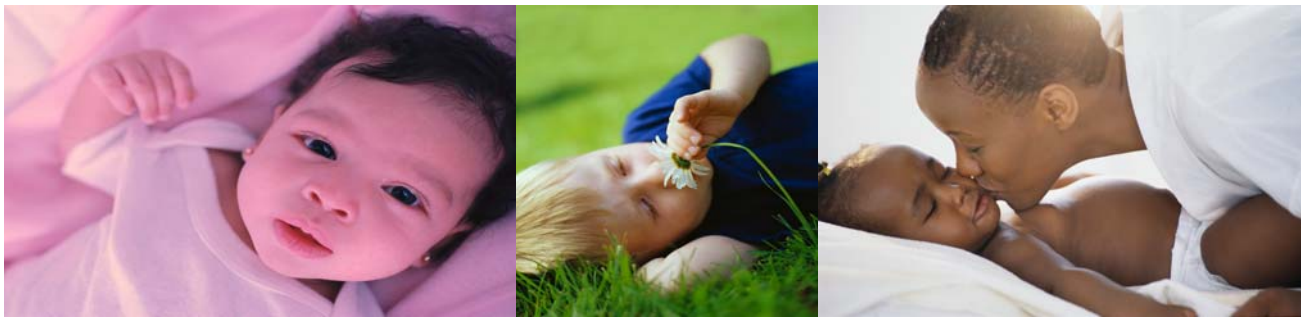
Alan Cobo-Lewis, University of Maine

Rob Hatch, Child Health Center

CDS Directors

Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

4. LOCAL COMMUNITY DOMAIN



Of all the domains, the concept of community-based resource centers has generated some visionary, yet feasible ideas. Maine can capitalize on its rich systems of coalitions to support broader systemic change and validate a broader public health study. These coalitions have the capability to initiate early childhood networks. For instance, the State Planning Office, a partner of the Early Childhood Initiative, is working to incorporate local early childhood data as a standard element into each municipal planning packet. Using MRTQ Registry mapping will further this ability.

Communities can review this data and implement the promising practices of the Healthy Maine Partnerships and Communities for Children and Youth into their own early childhood networks. For instance, the success of the "Totline" and use of school readiness indicators for evaluation of the Bucksport Bay Early childhood Network can support the 211 phone system we are piloting for statewide coordination. From informal partner conversations to actions requiring only nominal formality, local networks could burgeon in a climate that embraces early childhood as vital to the economic health and development of Maine.

4.1

Develop public-private partnerships for local child and family services infrastructure via "hubs" or co-located quality supports.

Where We Are Now

A Child Care Infant and Toddler Initiative Project is being developed for Androscoggin County that will provide a "hub" at the Child Care Resource Development Center. The "hub" will serve to organize the existing and newly developing systems that support children, age birth to three, by identifying where each child is in care and offering support to every child's caregiver. The project will follow their progress and development through their screening for Pre-K at age four. It will (a) connect families and their child care providers to other resources, (b) link caregivers to professional development and support, (c) track children's school readiness through Pre K, (d) implement a Strengthening Families pilot program, (e) expand on mental health services currently provided in child care programs, and (f) connect businesses with child care providers in a meaningful way. This research-based project will support and enhance the social-emotional development and mental health of infants and toddlers in this area and serve as a model.

Where We Want to Be

- Families and communities understand, respect, and seek infant/toddler services and supports.
- Families have increased access to services and support. All infants and toddlers at risk and not currently eligible for services are served. Providers have increased ability to care for children with identified disabilities.

- Child care providers have increased access to infant and toddler services. A shared understanding of Infant Toddler guidelines exists among providers and other professionals.
- Technical Assistance system is established to meet the demand.
- Families are strengthened, and their lives and their children are safe and free from violence.
- Children with special needs and behavioral challenges are always included and never excluded/expelled from child care and other programs.

WHEN
By Spring 2008
Inventory partnerships/facilities for hubs
By fall 2008
Begin standardized referral protocol Conduct Infant and Toddler Demonstration Project Pilot in Androscoggin County

WHO LEADS
Androscoggin County
Karen White, Infant Toddler Initiative
Carolyn Drugge, Early Childhood Division
Maureen Hickey, Head Start
Jill Downs, Center for Community Inclusion and Disability Studies
Sheryl Peavey, ECI
Western Maine ACCESS
Angie Bellefleur, Advocates for Children
Leslie Forstadt, University of Maine, Cooperative Extension and Margaret Chase Smith Policy Center
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

How to Get There

4.1.1 Recruit key stakeholders and existing collaboratives to work together to localize resources for parent education, provider education and supports, health consulting, and assurances of a medical home for each child and family.

4.1.2 Inventory existing partnerships and available facilities by community. Encourage development of community hubs for ECE locating programs.

4.1.3 Examine potential matriculation rates and availability of local school space to co-locate appropriate services or access to services in conjunction with other community spaces.

4.1.4 Create a menu of what businesses and communities can do to invest in early childhood initiatives (financial/non-financial). Collaborate with organizers of community and neighborhood events to promote the activities for families with young children.

4.1.5 Expand statewide family support infrastructure and develop shared vision for family support services.

4.1.6 Develop family support activities that build on family strengths, use peer-to-peer models, and increase family capacity to self-advocate.

4.1.7 Develop and disseminate a standardized referral protocol that all agencies can use to refer families to appropriate programs and coordinate services.

4.1.8 Implement Infant and Toddler Initiative Project in Androscoggin County.

4.2

Family Resource Center models including Coalitions will be implemented for all Maine communities.

Where We Are Now

- A Family Resource Center position paper was developed and approved by Task Force.
- Legislation submitted to include pilots and evaluation.
- Family Resource Coalition reviewed data and drafted proposal for piloting Family Resource Centers with evidence-based quality standards and components. Core Components align with DHHS Objectives: parent education, child development activities, resource and referral advice, drop-in availability, peer-to-peer supports, life skills education and advocacy.
- Pending funding and review by the newly established Commission to Develop a Strategic Priorities Plan for Maine's Young Children.
- Requested grant support for Vista (to begin in August 07). Recruitment of VISTA underway.
- Submitted legislation that may be included in the work of the Commission.

Where We Want to Be

- Twenty-five Maine communities will have a coordinated hub for family support services through Family Resource Centers/Coalitions
- There exists enhanced family capacity to support growth and development of Maine children.

WHEN
By Fall 2008
Five local communities will develop Family Resource Centers
By 2009
Fifteen local communities will develop Family Resource Centers

WHO LEADS
Candy Eaton
Jan Clarkin
Sheryl Peavey, ECI
Children's Cabinet
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

How to Get There

4.2.1 Recruit key stakeholders and existing collaboratives to work together on the goal to localize resources for parent education, provider education and supports, health consulting, and assurances of a medical home for each child and family.

4.2.2 Recruit key stakeholders to work together to develop viable family resource models.

4.2.3 Research and design viable family resource models and evaluate existing ones.

4.2.4 Identify best locations for Family Resource Centers.

4.2.5 Develop and disseminate "toolkit" to assist local communities in developing Family Resource Centers.

4.2.6 Expand number of Family Resource Centers throughout the state.

4.3

Expand the Communities for Children and Youth (C4CY) Initiative to include increased community-based projects focusing on young children.

Where We are Now

- Presence around the Task Force table has increased awareness of VISTAs with the intent to actively expand member participation in early childhood initiatives. C4CY set up several accounts so interested parties could apply; many flagged the opportunity for next year.
- As with most ventures, the first year barely scratches the surface of maximum partnership potential. An additional benefit of a closer tie between VISTA and the Task Force is that those present rather effortlessly provide examples of the strength of VISTA as a resource for Maine's non-profits in general, and, in particular, in the early childhood sector.
- This is the first year that the C4CY*VISTA project has made early childhood development one of its major goals; we integrated themes from the State's *Humane Systems Plan* into the overall Request for Sponsor Applications, requiring applicants to make a connection to one or more of the elements included in that document.
- The Maine DOE attributed to VISTA assistance: Thanks to VISTA, "…we've been able to move major cross systems early childhood work and relationship building forward by offering Pre-K Forums, as well as developing a website and creating a data base [of Maine's existing public four year old programs]." *Janine Blatt*
- Downeast Health Services' Early Childhood Team with the help of VISTA, hosted events, created monthly newsletters for parents and legislators, began a breastfeeding coalition in two counties; enhanced outreach to community partners, raised in in-kind and cash donations; utilized 67 volunteers, and more.
- VSA Arts of Maine (a non-profit that helps artists with disabilities through adult and youth programs) explored its ability to extend their program and professional development opportunities into early childhood education, but was unable to due to limited organizational capacity. The research is done; the interest is there! VSA's effort is yet another indicator of the breadth of Maine's interest in early childhood development and an organization's hope to broaden their service area to include our youngest residents.
- Adding to the Early Childhood Initiatives with VISTA in coming year will be United Way of Midcoast Maine, Family Resource Center, Waldo County Head Start, and Teen and Young Parent Child Care Program

Where We Want to Be

- C4CY has a VISTA Team Leader dedicated to focusing on early childhood using state plan.
- VISTA becomes resource for early childhood programs, services, and initiatives state wide.

WHEN
2007
C4CY Vista project will include a focus on young children
2008
Expand Vista ECE projects in 8 communities

WHO LEADS
Susan Savell, C4CY
Jan Clarkin, Children's Trust Fund
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

How to Get There

4.3.1 Expand C4CY Vista project to include community-based projects focusing on young children.

4.3.2 Encourage the 72 C4CY partners to be actively engaged in creating a statewide prevention system for early childhood.

4.3.3 Plan for and secure funding to host a statewide prevention conference to include C4CYs, CAN Councils, Home Visiting Coalition, OSA and Healthy Maine Partnerships.

5. STATEWIDE COMMUNITY DOMAIN

Early childhood is a stage of life that is often misunderstood. Many policymakers believe that it is the responsibility of the family, specifically parents, to provide all things for their children--health care, education, financial support, and other of life's basic necessities. For most of Maine's well-informed, capable parents being able to provide high quality, consistent, nurturing care and education is achievable. Working parents with quality health benefits can acquire medical homes, purchase preventive medical care and expert treatment. However, it remains a statewide community concern that there are 21, 000 children under the age of 18 in Maine who are not insured. (We don't have precise data on Maine's preschoolers without health insurance.)

The issue of caring for and educating Maine's youngest children is even more complex. First, the need for this care has become very important in a very short period of time--in terms of cultural understanding. Many community leaders and policy makers who came of age in the 1940s and 1950s do not have a personal experience with the need for out of home child care. And, even though the science around how essential are the first five years of life, that research as still not been fully integrated into the wider community consciousness.

Second, the business of providing Quality Early Care and Education programs is generally NOT lucrative. Early care and education programs for working parents do not generate a significant profit margin since the primary stream of revenue is from tuition fees to families—often single parents and low income earners. In Maine, early care and education is the fourth largest industry, yet its workforce struggles to earn a livable wage. In turn, accessibility, affordability and quality challenge working families. The issue is multi-faceted—quality early care and education and worker wages are intimately linked while school readiness and high literacy rates also have direct connections to quality early care and education programs.

5.1

Communities include early childhood in municipal planning and towns/cities undertake the cross disciplinary process of defining shared responsibility.

Where We Are Now

- Children's Cabinet and Task Force staff met with State Planning liaison to establish process by which to include quality care and education infrastructure, as part of Comprehensive Municipal Plans. Early Childhood Division – Child Care and Head Start is providing data on early care and education supply and demand to Maine State Planning Office to include in their comprehensive planning resource information. Child Care Resource Development Centers provide information on early care and education supply and demand to local groups through presentations and localized information.

Where We Want to Be

- Communities recognize the connection among oral, medical, social and emotional health, child care, and educational systems locally.
- Updated data is available by municipality about the early care and education capacity and service needs of families with young children.
- All municipalities address and plan for increase of quality early care and education facilities and programming within Plans.

How to Get There

5.1.1 Expand C4CY Vista project to include communities focusing on young children.

5.1.2 Identify and review needs assessments and data sources currently being used by communities to determine community need.

5.1.3 Develop a toolkit to assist local communities and the state with existing early childhood needs assessment process. Toolkit will help to compile early childhood data and identify missing data.

5.1.4 Develop protocol / template for orientation and training materials for members involved in planning and systems development that can be individualized at all levels.

5.1.5 Provide training and technical assistance to support community development of plans based on the needs assessment.

5.1.6 Select 3 communities to pilot the early childhood needs assessment toolkit. Provide support and technical assistance to communities piloting the toolkit. Make revisions to toolkit based on feedback from the communities piloting the toolkit.

5.1.7 Distribute toolkit to communities for widespread use.

5.1.8 Provide incentives for municipal/regional planning for ECE community infrastructure.

5.1.9 Ensure every town report includes early childhood needs in its town reports.

WHEN
By Winter 2007
Needs assessments and data sources reviewed by State Planning Office
By spring 2008
Protocol/template for training municipal planning developed
By summer 2008
Three community pilots developed

WHO LEADS
Invest Early Team
Stacey Benjamin, State Planning Office
Leslie Forstadt, University of Maine Cooperative Extension and Margaret Chase Smith Policy Center
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

5.2

Strengthen families by ensuring that parents, families, and providers have access to local and regional resource directories to connect them to concrete supports in times of need.

Where We Are Now

- Maine families have no single, free location to access critical, up-to-date information on local resources and supports they need. The exception as well as a model for information dissemination is Maine's network of child care resource and referral provided by Resource Development Centers (RDCs). There also exists resource supports for children with disabilities such as the Maine Parent Federation and systems of support for families from other cultures. Successful models in other states connect the 211 call to the local RDC to provide more in-depth information about early care and education providers. Maine families will be strengthened by the developing 211 system and the community partnerships necessary to make it successful.

Where We Want to Be

- All parents, families, providers have access to local and regional resource directories across Maine in various formats to ensure universal access including emphasis on meeting resource needs of families with special needs.
- Families are connected to and know where to secure concrete supports that are responsive to cultural, linguistic and developmental diversity in times of need.
- All state training for child and family service providers use resource directory and referral protocols.

How to Get There

5.2.1 Review existing directories and referral resources

5.2.2 Review strategies with consideration to materials and supports provided from a universal design/access perspective.

5.2.3 Clarify the role and scope of Maine's 211 system

5.2.4 Link existing systems or resource support and dissemination to make 211 seamless to the end user and create collaborative Memorandum of Understanding (MOU) among all other resource dissemination activities in Maine.

WHEN
By Fall 2008
Establish Statewide 211 system complete with area resource information
By Spring 2009
Replicate Bucksport Bay Area Early Childhood Network

WHO LEADS
United Way (211)
Jan Clarkin, Children's Trust Fund
Rita Fullerton, Resource Development Centers
Mainely Parents
Maine Association of Child Abuse and Neglect Prevention Councils
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

5.2.5 Change policies around agency knowledge of and use of local resources. Provide training to early care and education providers via the Strengthening Families Initiative to better know how to share information about supports and resources with families from a universal access and design perspective.

5.2.6 Work with DHHS and other relevant departments to develop collaboration policy to use standard resource directories and consistent array of services.

5.2.7 Assess impact of Bucksport Bay Area Early Childhood Network and consider replication.

5.2.8 Work with the Judicial Branch to share the Zero to Three "Babies and the Bench" concept.

5.3

Coordinate statewide "Invest Early" message about the value of investing in young children.

Where We Are Now

- Invest Early Team led by Attorney General Steve Rowe conducted 15 "Invest Early" presentations to business sector groups across Maine in 2007.
- Invest Early Team members partnered with private foundations and corporations to engage business leaders to build capacity for quality care and education in Portland Collaborative and Greater Waterville's Alliance on Early Care and Learning.
- Regional Developmental Centers created and distributed the Employer Tool Kit to educate employers about the various benefits they can offer to employees with young children.
- Invest Early Team members and Children's Cabinet staff met with Grow Smart Maine to explore including Invest Early focus in subsequent Brookings Report promotions in Maine.
- Invest Early members are working with Maine Development Foundation to include early childhood indicators in the Maine Measures of Growth Report.
- Proposal for National Governor's Association Grant funded in April 07. Summit planned for winter, 2007.
- LD 755 Resolve to Create the Commission to Develop a Strategic Priorities Plan for Maine's Young Children was passed by the legislature, spring 2007.
- Several pieces of legislation focusing on activities to improve early care and education for Maine's young children were heard before the legislature and acted upon in a variety of ways. The majority were subsumed by the Commission legislation or held over until the Commission is enacted and completes its report. Coordinated advocacy was managed by the Invest in ME Now coalition, ACCESS. The Child Care Advisory Council supported many of these issues. The Task Force work parallels much of the legislation. The legislation served to educate many members of the Maine legislature about these issues. They include:

(1.) *An Act to Increase Access to Child Care and Early Education for Maine's Working Families.* (Child Care Subsidies for low to middle income working families and Head Start in Maine with an emphasis on caring for infants, toddlers, and at risk children.)

*(2.) An Act to Enhance the Education Opportunities for Maine's Early Childhood (*Scholarships for Child Care Providers seeking higher education, and created a post secondary curriculum for those working with pre-school children with special needs.)

(3.) An Act to Improve Child Care Facilities in Maine ("Facility bond" to provide low/no interest loans to improve quality and availability of child care facilities in Maine.)

WHEN
By December, 2007
Commission makes report to Legislature
By winter 2007
Governor's Summit on Early Childhood held
Legislative Session, 2008
Legislature makes significant investment in early childhood
By spring/summer 2008
Additional summit with new legislative and gubernatorial candidates held

WHO LEADS
Pat Ende, Governor's office
ACCESS
Children's Cabinet
United Ways of Maine
RDCs
Child Care Advisory Council
Early Childhood Division
Jaci Holmes, DOE
Sheryl Peavey, ECI
Richard Aronson, MCDC
Karen White, Infant Toddler Initiative
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

(4.) *Child Care Tax Credits for Families with Children in Care.* (Removed some of the limitations on the child and dependent care tax credits available to Maine families.)

(5.) *Business Tax Credits to Provide Incentives for Employers Investing in Meeting the Child Care Needs of their Employees.* (Tax-based incentives for employers who choose in invest in the child care needed by their employees.)

(6.) *An Act to Invest in Children and Families through Family Resource Centers* (A series of community based "Family Resource Centers" to support all families with dependent children in those communities (with an emphasis on the young child.)

(7.) *An Act to Assure the Success of All Maine Families through Quality Early Care and Education.* (Funding for a variety of community-based programs intended to raise the quality of care for all children, including children with special needs.)

How to Get There

5.3.1 Provide support to the Legislative Commission on Early Care and Education to develop an incremental plan for the most effective state investment in comprehensive Early Care and Education.

5.3.2 Implement the Governor's Summit on Early Childhood, a high-level, policy think-tank to make recommendations on the Governor's Policy Agenda for Early Childhood, ways in which communities can implement the State Plan on Early Childhood, and actions to take on a local level to support early childhood.

5.3.3 Utilize State Offices to educate key constituencies on the importance of meeting the needs of this population (i.e. "Steve Rowe Road Show").

5.3.4 Expand on the current efforts to inform the local business communities to targeting other key constituencies (i.e. Law Enforcement, Local School District and PTA/PTOs, Hospitals etc.)

5.3.5 Utilize the Children's Cabinet and Governor's leadership to integrate the needs of the young child and the family of that child into state policies across the board.

5.3.6 Develop a media campaign to further inform the wider community around the needs/benefits of investments in the young child.

5.3.7 Replicate the employer/CEO forums to promote local/regional expansion and partnerships towards increased quality early care and education.

5.4

Generate public awareness of and interest in the efforts of the Task Force on Early Childhood.

Where We Are Now

Although the hard work, successes, and plans of the Task Force are reported in the Annual Children's Cabinet Report and through its website to all state agency partners and the Maine Legislature, the Task Force for Early Childhood remains limited in its ability to reach the greater Maine population of providers, professionals, parents, and advocates dedicated to the well being of young children. There remain many different local, regional, and statewide groups which drain the energy of many Task Force members. Other groups are not well aware of the important work of the Task Force. Individuals who are not located in Augusta and do not have expense reimbursements find it difficult to travel to meetings. Providers in nearly every domain cannot take time from direct service work to attend meetings. Parents and other family members cannot afford the cost of meetings in the state capitol. The website, dedicated marketing, and efforts at increased visibility will augment the work of the Task Force. Widespread implementation of Task Force goals and valuable reporting on the progress of direct Task Force activities will build confidence in the value of the Task Force.

Where We Want to Be

- Provider and public buy-in to the Task Force as a means to improve the well being of Maine's youngest citizens.

How to Get There

5.4.1 Find funding to reimburse parents for expenses such as childcare and travel to enable their participation on the Task Force.

5.4.2 Develop a Website for Early Childhood State Plan: (a) Identify interim host sites for state plan. (b) Work with Office of Child and Family Services and MeCDC on the ECI web pages, which include the state plan called Invest Early in Maine, ECI partners, and Task Force meeting minutes. (c) Develop protocol for posting updates and minutes to the ECI website. (d) Link web page prominently to Children's Cabinet site. (d) Generate a list of partners who can provide a link to the ECI website.

5.4.3 Communicate regularly the Invest Early strategies, results, and progress to Governor, Attorney General, Children's Cabinet. Cite benchmarks using KIDS COUNT indicators.

5.4.4 Implementation of the Plan. (a) Work with lead agencies to implement the State Humane Early Childhood Systems Plan, communicate implementation progress, and identify resource needs. (b) Formalize a mechanism within Task Force Steering Committee and Children's Cabinet for addressing obstacles or necessary modifications to the implementation plan for the State Humane Early Childhood Systems Plan.

5.4.5 Support Local Early Childhood Infrastructure. (a) Work with Bucksport Bay Early Childhood Network for Year 2 of pilot of a community assessment tool to develop its work into a "promising practice." (b) Support the Portland Childcare Collaborative and Greater Waterville Alliance.

5.4.6 Work with national organizations (e.g., National Alliance of Children's Trust, Future Search Networks, and Fight Crimes: Invest in Kids) who have expressed interest in Maine's innovative early childhood initiative.

5.4.7 Establish stronger connection to Healthy Maine Partnerships (an informal public health infrastructure), Office of Substance Abuse (Substance Abuse and Mental Health Services Administration State Incentive Grants awardees), Office of Child and Family Services, and Office of Integrate Access and Support (TANF.).

WHEN
By fall 2007
Conduct TF meetings around accomplishments and challenges of Progress Indicators
By spring 2008
ECI State Plan Website operable
By FY 2008-2009
Support key infrastructure components in each domain in the State Plan

WHO LEADS
Governor's Office and First Lady
Children's Cabinet, specifically DHHS, DOE
ECI
Attorney General's office
Key Partners and Collaborators with Lead Agencies *(See Table 1 in Appendix A, page 43 of this report)*

5.4.8 Support sustainability of systems change through evaluation and data. (a) Work with Maine Children's Alliance/Kids Count to optimally measure and report system change (in conjunction with Maternal and Child Health Block Grant, School Readiness Indicators Project, the Children's Cabinet and others). (b) Incorporate recommendations of the ECI into DHHS reorganizations and state policies.

5.4.9 Share updates on recommendation activities at Task Force monthly meetings as they relate to the Progress Indicators.

SOME FINAL THOUGHTS…

Our mission is to create and sustain a unified, statewide early childhood service system that provides essential resources, shares common standards for quality, and respects the diversity and uniqueness of all Maine's children and their families. With this system in place, we envision that families will assume responsibility to nurture, protect, and encourage the cognitive, emotional, ethical and physical development of their children. As well, Maine communities will assume responsibility to strengthen families and foster the healthy development of children.

The innovative framework of the early childhood stakeholders, the responsiveness to unique demographics in this rural state, the involvement and leadership from the Children's Cabinet, and the creative approaches to ensuring that work gets done have already captured the interest of our leadership. We have identified the resources and needs of our state and have drafted recommendations to achieve change. Our mission embraces a future that not only values the child, but also considers the family, community, and state resources that support each child. As we move forward, we will maintain a focus on the relationships among the stakeholders at our table and make sure we meet others at their "tables" as well. Guiding our work will be Kenosha County, Wisconsin's *14 Steps to an Integrated Service Center* list, including:

√ **Approach All Obstacles, Barriers, and Problems as Resolvable -** A positive attitude is essential. To achieve success, one must expect success. Management must create an environment for success for customers and staff.

√ **Integrate -** Not Just Collocate. It is not enough to locate different agencies in the same building. Services and functions need to be integrated to the largest extent possible to reduce duplication of effort and ensure quality customer service.

√ **Plan -** But Do Not Over Plan. Just do it. Let the collaborative adventure evolve naturally.

√ **Articulate a Common Mission -** The time and energy needed to develop a mission statement that is inclusive and mutually supported is well worth the effort.

√ **Implement Incrementally -** Begin small. Pilot integrated services with voluntary staff. Let the success of initial efforts convert reluctant participants.

√ **Establish an Inter-Agency Knowledge Base Prior to Collocation -** Fear of the unknown is one of our greatest nemeses. Bridge the knowledge gap first.[34]

As always, Maine's approach to collaboration will also employ the Future Search principles.

- Getting the Whole System in the Room
- Putting the Focal Issue in Global Perspective
- Seeking Common Ground and Desirable Futures
- Taking Responsibility for Action: Commitment to Implementation

While we can abide by these guiding principles, it is also important to model them and to make sure that every meeting is facilitated in a way that does not allow problem solving before the entire issue is understood and does not disregard conflict as a way of getting to common ground[35].

[34] Ragan, Mark. *Building Better Human Service Systems: Integrating Services for Income Support and Related Programs*. Prepared for the Annie E. Casey Foundation by the Rockefeller Institute of Government. Albany, HY: 2003.
[35] Janoff, S. and Weisbord, M. *Don't Just Do Something, Stand There! Ten Principles for Leading Meetings That Matter*. Berrett-Koehler Publishers, San Francisco, CA: 2007.

APPENDIX A:
INVEST EARLY IN MAINE PARTNERS AND COLLABORATORS

Partners/ Collaborations	2006 Task Force Steering Committee or formal partnership	Role in the Implementation of the INVEST EARLY state plan by Domain and Goal R: Responsible Lead				
		FAMILY	**HEALTH**	**ECE**	**LOCAL**	**STATE**
ACCESS (Alliance for Child Care, Education and Supporting Services)			**2.1, 2.2, 2.3**	**3.1-3.4R**	**4.1 R**	**5.3 R**
Advocates for Children		**1.2 R**			**4.1 R**	
American Academy of Pediatrics, Maine Chapter	Entwood	**1.1 R** **1.2**	**2.1, 2.3, 2.6, 2.7**			**5.3**
Anthem Blue Cross/Blue Shield	Kuhn					**5.3**
Aroostook Council for Healthy Families		**1.2 R**				
Attorney General's Office	AG Rowe		**2.2**			**5.3-5.4R**
Autism Society	Intrieri Cronin			**3.5**		
Bucksport Bay Area Early Childhood Network			**2.6 R**			**5.2**
Center for Community Inclusion and Disability Studies (UM-CCIDS) Child Care Plus ME, LEARNS	Zeph, Rainey	**1.1** **1.2**	**2.1, 2.2** **2.3 R, 2.5 R** **2.7**	**3.1** **3.2 R** **3.5 R**	**4.1 R**	**5.2, 5.3** **5.4**
Chamber of Commerce						**5.3**

Partners/ Collaborations	2006 Task Force Steering Committee or formal partnership	Role in the Implementation of the INVEST EARLY state plan by Domain and Goal R: Responsible Lead				
		FAMILY	**HEALTH**	**ECE**	**LOCAL**	**STATE**
Child Abuse and Neglect Councils	Clarkin	**1.1, 1.2**			**4.1, 4.2 R 4.3**	**5.2 R**
Child and Family Opportunities			**2.5**			
Child Care Advisory Council	Drugge		**2.5 R**	**3.1-3.5 R**		**5.3 R**
Child Care Licensing Unit, DHHS			**2.5**	**3.2 R**		
Child Care Services of York County	Hager			**3.1-3.5 R**		
Child Development Services	Cobo-Lewis, Hannigan	**1.2**	**2.1**	**3.5 R**	**4.1**	
Child Health Center	Hatch	**1.2 R**		**3.5 R**	**4.1**	
Child Welfare, OCFS			**2.2, 2.7**			
Children with Special Health Care Needs, MeCDC		**1.1**	**2.7 R**			
Children's Behavioral Health, OCFS	O'Brien		**2.2, 2.3 R**		**4.1**	
Children's Lead Poisoning Prevention Program, MeCDC			**2.4, 2.5R**			
Coalition for Environmentally Safe Communities			**2.4 R**			
Communities for Children and Youth	Savell	**1.1**			**4.1, 4.2 4.3 R**	**5.1, 5.3R**
Department of Education	Blatt, Holmes		**2.1, 2.4**	**3.1- 3.5 R**	**4.1 R**	**5.3R,5.4R**
Department of Labor	Gilbert			**3.2**		
Department of Public Safety			**2.1**			
Dept of Economic and Community Development	Dancause					
Dept. of Environmental Protection			**2.4**			
Disability Rights Center				**3.5**		
Early Care and Education providers		**1.1**	**2.1, 2.7**	**3.3**	**4.3**	
Early Childhood Division, OCFS, DHHS	Drugge Woolley		**2.3,2.5 R 2.7 R**	**3.1-3.4 R**	**4.1 R 4.2**	**5.1 R 5.3 R**

Partners/ Collaborations	2006 Task Force Steering Committee or formal partnership	Role in the Implementation of the INVEST EARLY state plan by Domain and Goal R: Responsible Lead				
		FAMILY	**HEALTH**	**ECE**	**LOCAL**	**STATE**
					4.3	**5.4 R**
ECI DIRECTOR	Peavey	**1.1 -1.2 R**		**3.5 R**	**4.1-4.3R**	**5.3&5.4 R**
Evidence-Based Practices Advisory Council	Cook		**2.3**			
Family Literacy Programs	Hughes	**1.2**				
Family Resource Coalition	Eaton		**2.1**			
Federally Qualified Health Center (FQHC)			**2.6**			
Fight Crime: Invest In Kids *Maine*	Gore			**3.1-3.4**		**5.3**
Four Square Foundation	Russ					**5.3**
Governor's Office	Ende			**3.1, 3.2**		**5.1, 5.3R 5.4**
Grow Smart Maine				**3.1, 3.2**		**5.3**
Hancock County Children's Council	Eaton				**4.2 R**	
Head Start/Early Head Start	Pino	**1.2**	**2.7 R**		**4.1 R**	
Healthy Futures Community Nurses			**2.1**			
Healthy Maine Partnerships		**1.1**			**4.3**	
Higher Ed Institutions		**1.1**		**3.2**	**4.1, 4.2**	
Home Visiting Coalition	Clarkin	**1.2 -1.2 R**	**2.1, 2.2, 2.6**		**4.1, 4.3**	
Infant Toddler Initiative, Central ME Community College			**2.3 R**	**3.4 R**	**4.1 R**	**5.3 R**
Injury Prevention Program, MeCDC			**2.1, 2.2**			
Karen Baldacci, First Lady	Chair					**5.3&5.4 R**
Kids Run Better Unleaded			**2.4**			
KVCAP and other Community Action Agencies		**1.2R**	**2.7 R**		**4.1, 4.2**	
Lead Elimination Advisory Council of ME (LEAd-ME)			**2.4R**			
Local Elementary Schools		**1.1**		**3.5**		
Local Libraries	Entwood	**1.1**				

Partners/ Collaborations	2006 Task Force Steering Committee or formal partnership	Role in the Implementation of the INVEST EARLY state plan by Domain and Goal R: Responsible Lead				
		FAMILY	**HEALTH**	**ECE**	**LOCAL**	**STATE**
Local Businesses						**5.3**
Maine Academy of Family Physicians		**1.1**	**2.1, 2.3, 2.6**			**5.3**
Maine Administrators of Services for Children with Disabilities			**2.3**			
Maine Association for Infant Mental Health (MeAIMH)	Weil	**1.2**	**2.3 R, 2.5**	**3.5R**	**4.1**	
Maine Center for Disease Control and Prevention, (MeCDC) **FISCAL AGENT**	Aronson	**1.1** **1.2**	**2.1** **2.4**			**5.3 R** **5.4**
Maine Child Care Director's Association				**3.1 -3.3 R**		
Maine Children's Alliance	Goldberg		**2.2, 2.7**			**5.1, 5.4**
Maine Children's Cabinet	Sterling		**2.1**			**5.1, 5.4**
Maine Children's Trust Fund	Clarkin	**1.2 R**	**2.1, 2.2**		**4.2 R, 4.3**	**5.2 R**
Maine Dental Access Coalition			**2.7 R**			
Maine Development Foundation						**5.3**
Maine Developmental Disabilities Council	Bell	**1.1**	**3.5 R**			
Maine Family Child Care Association				**3.1-3.3 R**		
Maine General Hospital/ Maine Medical Center		**1.2**				
Maine Humanities Council	Prouty				**4.1**	
Maine Immunization Program, MeCDC	Ranslow	**1.2 R**	**2.1, 2.4, 2.5-2.6**			
Maine Oral Health Program, MeCDC		**1.2**	**2.5 R, 2.7 R**			
Maine Parent Federation		**1.1**	**2.3**	**3.5**		**5.2**
Maine Roads to Quality	Dean	**1.2**	**2.1, 2.3**	**3.2-3 R**		**5.3**
Maine State Legislature				**3.1, 3.2 3.5R**		**5.3**
Mainely Parents		**1.1**				**5.2 R**
March of Dimes, Maine Chapter	Schulberger		**2.1**	**3.5**		

Partners/ Collaborations	2006 Task Force Steering Committee or formal partnership	Role in the Implementation of the INVEST EARLY state plan by Domain and Goal R: Responsible Lead				
		FAMILY	**HEALTH**	**ECE**	**LOCAL**	**STATE**
Maternal and Infant Mortality and Resiliency Review Panel (MIMRR)	Aronson		**2.1**			
Mobile Oral Health Providers (Tooth Ferry Program)			**2.7**			
MSEA-SEIU	Walshe			**3.2 R**		**5.3**
Municipal Planning Offices						**5.1**
Muskie School, USM					**4.3**	
Office of MaineCare Services, DHHS		**1.2**	**2.1 R** **2.2, 2.5**			
Office of Rural Health and Primary Care, MeCDC		**1.1**	**2.5, 2.7 R**			
Parents	Dawbin	**1.1**				**5.3, 5.4**
Physicians, Medical Homes, Hospitals	Richardson	**1.1, 1.2**			**4.2**	
Public Health Nursing, MeCDC	Bridge	**1.1** **1.2**	**2.1, 2.2** **2.4, 2.6**			
Resource Development Centers	Fullerton	**1.1** **1.2**	**2.1-2.5**	**3.1-3.4 R**	**4.1**	**5.1, 5.2 R** **5.3 R**
Sadie and Harry Davis Foundation			**2.7**			
Special Children's Friends		**1.1**				
Spurwink	Butler	**1.1**	**2.3**			
State Planning Office						**5.1 R**
Sweetser		**1.1**	**2.3**			
THRIVE Initiative (Trauma Informed System of Care)	Perez		**2.3R**		**4.1**	
United Ways of Maine	DeRosier Lindsay	**1.1**			**4.1, 4.2,** **4.3**	**5.1, 5.2 R** **5.3 R**
Univ. of Maine Cooperative Extension, Waldo County Parents Are Teachers Too	LaHaye	**1.2 R**				

Partners/ Collaborations	2006 Task Force Steering Committee or formal partnership	Role in the Implementation of the INVEST EARLY state plan by Domain and Goal R: Responsible Lead				
		FAMILY	**HEALTH**	**ECE**	**LOCAL**	**STATE**
University of Maine, Margaret Chase Smith Policy Center and University of Maine Cooperative Extension	Forstadt	**1.2 R**	**2.3**		**4.1**	**5.1**
University of Maine, Psychology Dept	Cobo-Lewis		**2.3**	**3.3**		
WIC, MeCDC		**1.1**	**2.1, 2.2**			
Woodfords Family Services	Farnsworth			**3.5**		

APPENDIX B: PROJECT TIMELINE SUMMARY

Listed below are specific outcomes expected by timeframe for each of the goals listed in Maine's Invest Early state plan. These are time-specific outcomes with an end date within the next two years; others may be ongoing, as can be expected with systems change efforts.

Seasonal Timeframe	FAMILY	HEALTH	EARLY CARE AND EDUCATION	LOCAL Community	STATE Community
FALL 07			3.4 Final regional Pre-K public forums held. 3.4 Pre K Standards completed.		5.3 Host Governor's Summit on Early Childhood 5.4 Work closely with Early Childhood Investment Commission; Conduct TFEC meetings around accomplishments and challenges of Progress Indicators
WINTER 07-08	1.2 Funding formula for FY 09 HV contracts 1.2 MOU between OCFS and MCH	2.3 Infant Mental Health training and Child Parent Psychotherapy incorporated as evidence based practice for children under five. 2.7 Report the dental shortage areas and impact on young children, targeting children with special health needs.	3.3 Implement QRS statewide 3.4 Compile report on Pre K Forums with strategies to move forward.	4.1 Inventory partnerships/facilities for hubs. 4.3 C4CY Vista project will include community-based projects focusing on young children.	5.1 Needs Assessments and data sources reviewed with State Planning Office 5.3 Invest Early Commission makes it report to Legislature

Seasonal Timeframe	FAMILY	HEALTH	EARLY CARE AND EDUCATION	LOCAL Community	STATE Community
SPRING 08		2.1 Pilot Strengthening Families Initiative among Early Head Start and Head Start programs. 2.1 Determine next steps for incorporating Strengthening Families framework into statewide training practices.	3.3 Provide QRS incentives for providers 3.4 Pilot Collaboration Coaching Model	4.3 Expand Vista ECE projects to be in eight communities	5.1 Protocol/template for training municipal planning developed 5.3 Increased investment in early childhood 5.4 ECE State Plan Website operable 5.4 Conduct statewide marketing campaign and comprehensive visibility activities
SUMMER 08	1.1 Family networks are parent-organized and parent-led. Thus, network development is a constant activity with networks forming and changing as parent leadership changes.	2.2 Children's Cabinet assures that administrative systems are revised, services' implementation and outcomes are monitored, and duplication among services is reduced. 2.7 Fund more diverse sites to deliver oral health care.	3.2 Cost-benefit analysis on ECE Workforce 3.5 DOE-DHHS MOU completed 3.5 Child Development Services Training re-vamped		5.1 Three community pilots using State Planning Office ECE data

Seasonal Timeframe	FAMILY	HEALTH	EARLY CARE AND EDUCATION	LOCAL Community	STATE Community
FALL 08	1.2 Fiscal plan for expansion and to serve prenatal families 1.2 Develop training tract with Maine Roads to Quality (MRTQ) 1.2 Home visiting Registry established with MRTQ	2.1 Provide enhanced Maine Care payment to providers for the EPSDT screening 2.4 All pediatric health care and all providers at child and family system points of entry will understand how to assess for lead exposure risk, routinely asses, and encourage lead screening.	3.5 Child Development Services Program reorganized	4.1 Begin Standardized referral protocol workgroup 4.1 Infant and Toddler Demonstration Project Piloted in Androscoggin County 4.2 Five local communities will develop Family Resource Centers	5.2 Establish Statewide 211 system complete with area resource information 5.3 Host additional summit with new legislative and gubernatorial candidates 5.4 Implement elements of all goals; implement two goals in each domain in the State Plan. Support key infrastructure components.
WINTER 08-09	1.1 Ten new family networks in 2008-9.	2.6 Begin to Implement Comprehensive Immunization Strategic Plan	3.2 Increased training for ECE Workforce 3.2 Improved technical assistance for ECE Workforce 3.2 Competency benchmarks for ECE Workforce 3.2 More accessible degree programs for ECE Workforce		

Seasonal Timeframe	FAMILY	HEALTH	EARLY CARE AND EDUCATION	LOCAL Community	STATE Community
SPRING 09			3.1 Fund initiative to increase licensed, quality child care, improve quality of existing programs, advance caregiver education and compensation, and assist parents in paying for child care.		5.2 Replicate Bucksport Bay Area Early Childhood Network
SUMMER 09	1.1 Schools in network communities use MFN as link to families with newborns.	2.2 Issues of confidentiality and multiple eligibility and payment conflicts will be resolved.	3.3 Evaluate use of incentives, use of training, and community comprehension for QRS		
FALL 09	1.2 Fund longitudinal study on families in home visiting and school readiness 1.2 Develop core curriculum with Best Practices	2.7 Enhance workforce recruitment, training of dental professionals, and promotion of dental careers by 25%.		4.2 Five local communities will develop Family Resource Centers	

Seasonal Timeframe	FAMILY	HEALTH	EARLY CARE AND EDUCATION	LOCAL Community	STATE Community
WINTER 09-10		2.3 Childhood/infant mental health specialists will be in doctor's offices/health clinics. 2.3 Child care mental health consultants will be provided. 2.4 All child and family system points of entry will serve to routinely screed and refer families for lead exposure. 2.5 Child Care Health Consultants are available to child care providers. 2.7 Provide early preventive oral care to 50% more children birth to three in a range of health care settings			

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner